*PHYSICIANS' EDITION*

# PHOTOGRAPHIC ATLAS

OF THE

# DISEASES OF THE SKIN

IN FOUR VOLUMES

*A Series of Ninety-six Plates, Comprising nearly Two Hundred Illustrations, with Descriptive Text, and a Treatise on Cutaneous Therapeutics*

BY

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## LEPRA

LEPROSY is a chronic infectious disease which involves not only the skin but the nerves and many other organs of the body. It is probably caused by the bacillus lepræ, runs a very slow course, and usually terminates fatally. In its clinical aspect leprosy presents a wide variation, and there are two classes of cases which look quite unlike each other, though equally typical of the disease. In some cases the skin is principally affected, and characteristic nodules and macules are observed. In other cases the nervous system appears to bear the brunt of the attack, and loss of sensation and muscular atrophy are the prominent symptoms. For convenience of description, writers have usually divided leprosy into three varieties: the tubercular, the macular, and the anæsthetic. Many cases can be readily classed in one of these divisions; others are of a mixed form and present characteristics of each variety.

Tubercular leprosy may begin with a slight eruption of macules of a brownish-red hue, but sooner or later a group of characteristic lumps or nodules appears upon the face, forearms, and elsewhere. These occurring, as they frequently do, above the eyebrows, change the patient's expression, and produce a typical facies even in the early stage of the disease. When the tubercles increase in size upon the forehead, the face often presents a peculiar leonine expression; and when the cheeks, chin, and lobes of the ears are affected, a hideous aspect is sometimes produced. The tubercles may remain unchanged in size and appearance for years, or they may disappear, and a crop of new ones take their place. In severe cases they show a marked tendency to ulcerate, particularly upon the extremities. Locomotion is impeded, and the swollen hands become almost useless. The

lymphatic glands are generally swollen, and recurring attacks of fever, with a temporary outbreak of red nodules suggestive of erythema nodosum, are not uncommon. A typical plantar ulcer is frequently seen in the course of the disease, and often resists all attempts at healing.

The mucous membrane is liable to become affected, as well as the skin. Small tubercles appear upon the velum of the palate and in the larynx, and the voice becomes husky and weak. The nasal membrane is thickened, and the patient breathes through the mouth. Nodules appear upon the conjunctiva, involve the iris, and tend to produce a partial loss of sight.

The tubercular is generally considered to be the most serious form of leprosy, and after a slow and painful course of eight or ten years the patient usually succumbs to exhaustion, or death ensues from a pneumonia or enteritis undoubtedly of leprous origin and due to morbid growths in the lungs or intestines. While this is the typical course of tubercular leprosy, it must be borne in mind that all cases are not equally severe and do not present the abhorrent symptoms commonly associated with the disease. I have known lepers whose faces were far less unsightly than the faces of patients with ordinary acne, whose suffering could not be compared with that so often occasioned by eczema, and who are now practically well, in spite of the common statement and general belief that leprosy is an incurable disease.

The anæsthetic form of leprosy is one in which the nervous system is principally affected, and the symptoms are in the main such as might result from multiple neuritis of other than leprous origin. It is the more common type of leprosy in tropical regions, while the tubercular form appears to prevail in colder climates. It is characterized by the development of macular and anæsthetic patches, muscular paralysis and atrophy, bullous eruptions and mutilating ulcers. The anæsthetic patches may be of variable size and correspond with the macular areas, or affect skin of normal appearance. The paralysis and atrophy give to the face a characteristic expression. The eyebrows and eyelashes fall, although the scalp may remain free from all manifestation of disease. The hands are frequently converted into rigid

claws, the fingers being flexed and bent backward by the contraction of the tendons. The outbreak of bullæ is common, especially upon the extremities and most annoying, as they are very apt to form ulcers which not only persist, but frequently perforate the phalangeal joints, and lead to extensive mutilation of the hands and feet. In many cases of the anæsthetic type these members become transformed into mere stumps or clubs. The nerves become enlarged by a leprous deposit, and the ulnar can usually be readily felt at the elbow, like a fine whipcord. At first this is hyperæsthetic, and pressure upon it will cause a patient to wince or jump, but later in the course of the disease the sensibility is almost entirely gone.

The macular form of leprosy may be associated with either of those already described, or appear with no tubercles and but a slight amount of anæsthesia. The macules may be preceded by a loss of sensation, but are sometimes hyperæsthetic at the beginning and gradually lose their sensibility. They are rounded or oval, of a dull reddish-brown or bronzed hue, and tend to whiten in the centre, leaving a narrow band at the border of the patch, which is somewhat elevated. The whole patch may be slightly furfuraceous. The face, trunk, or extremities may be the seat of these patches. Upon the back they may coalesce and spread in a serpiginous manner.

The etiology of leprosy appears to have become more definite since the discovery of the bacillus lepræ by Hansen, in 1874. While the presence of bacilli in nodules, lymphatics, and internal organs is not an absolute proof that they are the cause, and not a product, of the disease, and although inoculations of leprous tissue in the human subject have proved negative or uncertain, it is nevertheless a fair assumption that leprosy is one of the germ diseases, and that, as in the case of tuberculosis, the disease develops through the entrance of bacilli into the system. How these enter is an unsettled question.

The contagiousness of leprosy has been both accepted and denied by the highest authorities. In the light of our present knowledge it seems possible, and, indeed, probable, that the disease may be transmitted through direct contact; but when we consider that men and women live for years with leprous

wives and husbands without contracting the disease, and that a few months' sojourn in a leprous country is far more dangerous than nursing lepers in a climate where leprosy is not endemic, it would seem that the disease were contagious only in a very slight degree, if at all.

As a matter of fact, leprosy does not spread except in certain localities where climatic influences, peculiarities of diet, uncleanly habits, or some other unknown factor tends to favor its development in a healthy person. In the city of New York a dozen or more lepers may have been found at any time during the past twenty years, either in or out of hospital, and yet there has never been a single case reported in which leprosy has been contracted by any one associating with those afflicted by this dreaded disease.

As leprosy is endemic in Iceland as well as in countries near the equator, neither heat nor cold seems to play a part in its causation; but in damp regions, whether inland or by the sea, the disease appears to be especially prevalent.

The hereditary nature of leprosy has been claimed, and the occurrence of cases in successive generations, and its limitation to a few families in any locality, would seem at first thought to substantiate the view that it is transmissible in this way, but no positive proof of heredity in this disease has as yet been presented. The disease is never congenital, like syphilis. It is rare in childhood, unlike tuberculosis. When children of leprous parentage present undoubted manifestations of the disease, it is fair to assume that it has been acquired, and not transmitted by heredity. The descendants of Norwegian lepers who have settled in Minnesota and other Northwestern States have never, so far as known, developed the disease.

In the treatment of leprosy a change of residence is of the greatest importance. Cases which are bound to terminate fatally in lazarettos in countries where the disease prevails—notwithstanding the fact that they may have the best medical care—will often improve spontaneously when removed to a region where leprosy shows no tendency to increase. A prominent professional gentleman who has been under my observation for the past twenty years contracted the disease during a sojourn of two

years in South America. A few small but unmistakable macules developed about ten years later, and he complained of numbness in his hands. Treatment in his case consisted of chaulmoogra oil, which he took intermittently for a short time, and then discontinued it on the ground that it was worse than the disease. For many years he has had practically no treatment, and the disease has never interfered with his work nor given him any annoyance. Had he remained in South America I have little doubt but that the disease would have run its usual course.

Among the internal remedies which have been used with more or less success in the treatment of leprosy may be mentioned chaulmoogra and gurjun oils, strychnia, and salicylate of sodium. Difference of opinion has been expressed as to the value of these remedies, and the fact should be borne in mind that good results may be obtained from a remedy in a country where leprosy tends to improvement, while its beneficial action may be counteracted by the conditions surrounding a patient in a lazaretto or the place where the disease was contracted. I have seen a number of patients improve steadily under the use of chaulmoogra oil, and a few become practically and permanently cured of the disease. Without doubt, much of this improvement has been due to a change of climate and to the natural tendency of the disease to improve under the best hygienic conditions. The oil, however, has produced a notable result in some cases, and appears to be the most efficient internal remedy which I have tried. The oil should be given in rapidly increasing doses, if the patient's stomach will tolerate it, until one hundred drops are taken daily. Some patients can take more, but, sooner or later, nausea is apt to compel a diminution of the dose or a temporary cessation of the remedy. It should be taken in the form of an emulsion, and may be added to any emulsion of cod-liver oil and taken after each meal.

When patients are unable to take this remedy, even in small doses, or in cases where the stomach shows signs of rebelling after its prolonged administration, the tincture of nux vomica, sulphate of strychnia, or hoang-nan may be given in its place. Strychnia is said to be of

especial value in the anæsthetic type of the disease. It will certainly do good as a nerve tonic in most cases, whether or not it has any direct effect upon the leprosy. Arning has obtained good results in Hawaii from the administration of salicylate of sodium, fifteen grains three times a day.

In the local treatment of leprosy, gurjun oil has been highly praised as an inunction as well as an internal remedy. While baths and inunctions may improve the general condition of the patient by contributing greatly to his comfort, they cannot be expected to influence the course of the disease. For the large and unsightly nodules, the use of a reducing agent such as resorcin has been recommended by Unna. This may be applied in the form of an ointment or varnish of twenty to fifty per cent. strength, and repeated after the skin has peeled from the surface of the nodules. This will produce a notable reduction of their size in a short time. For the indolent and obstinate ulceration that often occurs, the alternating use of aristol powder and mercurial plaster will be found of service in most cases. Sometimes, thorough cauterization or curetting of the ulcer is advisable.

The segregation of lepers in countries where the disease prevails is highly important and tends to check its spread. In a climate where the disease is not endemic and where patients tend to improve spontaneously the compulsory segregation of all cases is quite unnecessary, and any attempt to carry this out through legal enactments, as has been proposed, would lead to rank injustice. The few lepers constantly to be found in the city of New York and other Atlantic seaports are no menace to the health of the community. The prevalent dread of leprosy among those who know nothing of the disease is as absurd as it is unfounded. Newspapers may find it to their advantage to make a great hue and cry over every case of leprosy discovered in a Chinese laundry or elsewhere, but members of the medical profession, aware of the fact that the disease has never shown any tendency to spread in this region, should do all in their power to allay the painful apprehension of harm on the part of the public, instead of increasing it by talking and writing of a danger that does not exist.

The prognosis of leprosy is serious, though not necessarily fatal. The common belief, founded on the statements of many authoritative writers, that leprosy is an incurable disease, is not in accordance with facts. Leprosy can be cured, has been cured, and would be cured in many cases if the patient were not given to understand that his condition is hopeless and speedy death inevitable. If you, my kind reader, or I, both in perfect health, were told that we had been stricken by some incurable plague and could not possibly recover; if we were shunned by our dearest friends and finally driven from home; if we were condemned by municipal authority to solitary confinement in some cell or barricaded hovel, and food poked at us through a window, how long do you imagine we would live? And yet this is the way some cases of leprosy are treated at the close of the nineteenth century, and without even a protest from the medical profession.

## LICHEN PLANUS

The older dermatologists, following the lead of Willan, applied the term lichen to all papular eruptions, whether eczematous, urticarial, or syphilitic in character. Hebra was the first to claim that the name should be restricted to those diseases in which papules are the sole and characteristic lesions. In the diseases to which he applied the term lichen, the papular lesions persist as such throughout their entire course and never undergo a transformation into vesicles or pustules, as so frequently happens in eczema and syphilis. There are three such diseases now recognized, and known as lichen planus, lichen ruber, and lichen scrofulosus.

Lichen planus is a disease characterized by the eruption of flattened, shining, angular papules of a purplish red hue. They usually have a central depression and become slightly scaly before disappearing. The lesions vary in size in different cases, but in any given case little or no variation is noted. They are usually about the size of a large pin's head. They do not increase at the periphery and form a patch as do the small scaly papules of psoriasis.

but by an increase in number and by aggregation they usually form patches of irregular shape which tend to become more or less scaly.

The eruption is usually symmetrical and appears most frequently upon the inner aspect of the forearms, around the waist, and on the thighs. In exceptional cases the greater portion of the trunk and extremities may be covered. The lesions may remain isolated throughout the course of the disease, but they commonly form in groups which coalesce into patches. A marked tendency of the lesions to develop in a line, especially upon a scratch, is often noted, and in severe cases patches of long standing sometimes flatten in the centre and leave scaly rings. Upon the thighs and legs a hypertrophic form of the disease is apt to occur in which the patches are considerably elevated and usually intensely pruritic. The surface of these hypertrophic patches may be quite smooth if not excoriated, or it may be roughened like a piece of coarse sand-paper. When lichen planus disappears it is apt to leave a pigmentation of the skin which may be very marked in some cases.

The etiology of lichen planus is very obscure. It occurs in both sexes and usually in adult life. Although in many instances a patient may be apparently in excellent health, it is fair to assume that the eruption is not a dispensation of Providence, but due to some internal derangement for which the patient is unconsciously responsible and for which the best remedy is a radical change in his or her ordinary habits of life. I have known a very strict limitation of the diet to bread and milk to accomplish a far more brilliant and speedy result in a case of generalized lichen planus than could possibly be hoped for through local applications. How it did it cannot be definitely stated. Whether it would accomplish the same result in many other cases is doubtful. But such a fact is convincing to me that the cause of the disease must be looked for beneath the skin, and explains the fact that local remedies are so frequently of little or no value.

Some have attributed the disease to nervous exhaustion and others to digestive or uterine disturbance, but in many cases the internal derangement cannot be definitely located. The internal causes are similar to if not

identical with those which cause eczema. But why one patient with nervous exhaustion or indigestion should have lichen planus and another one suffer from eczema is a question not readily answered.

The treatment of the patient who suffers from lichen planus is far more important than the treatment of the eruption. Most writers agree in the glittering generality that iron, quinine, arsenic, cod-liver oil, pepsin, bismuth, alkalies, etc., may be prescribed according to circumstances, but in many cases there is no anæmia, no malaria, no sign of struma, no indigestion, nor even a trace of the popular uric acid diathesis, and the above routine remedies are no more likely to do good than venesection, the great routine panacea of former days. I do not object to these remedies whenever there exists a definite indication for any one of them, but I do protest against the too common idea that there is nothing for a physician to do in a case of lichen planus but to give medicine and to prescribe local applications. The patient's general condition can usually be improved, and this can be done by hygienic rather than by medicinal measures. No one, I imagine, ever saw an athlete in training, with an eruption of lichen planus. In my opinion the best method of curing the disease is to put the patient under a course of training which will tend to bring him or her to an approximation of the highest possible physical and mental condition. This can usually be done in lichen planus, as in many other skin diseases, by good air, good food, good company, and a systematic alternation of hard work and perfect rest, while an undue or a sole reliance upon pharmacopœial remedies can rarely if ever accomplish it.

Arsenic has been highly recommended and is commonly prescribed in this disease. It sometimes does good, but as frequently, perhaps, does harm through being prescribed when the eruption is acutely inflamed and spreading, instead of being withheld until the inflammatory stage has passed and the eruption shows a tendency to spontaneous disappearance. Tilbury Fox claimed that arsenic always made his cases worse, and Malcolm Morris, Pringle, and other English dermatologists have since regarded the remedy with marked disfavor.

At the suggestion of the older Professor Bœck, of Christiania, Dr. R. W. Taylor advises the administration of fifteen grains of potassium chlorate in four ounces of water, fifteen minutes after eating, followed in another fifteen minutes by twenty drops of dilute nitric acid in a wineglass of water. Blaschko advises the internal use of antipyrin to relieve the severe itching. Liveing and Lusk have spoken highly of corrosive sublimate as an internal remedy, and at the Vanderbilt Clinic a number of cases have improved rapidly after the administration of protiodide of mercury tablets, although no indication of syphilis was present and no connection of the two diseases was imagined.

Local applications may be of service by soothing the skin and allaying the itching in the early and spreading stage of the eruption, or by stimulating the skin and hastening the disappearance of the eruption when it shows a disposition to yield. It is a noteworthy fact, however, that there are few if any inflammatory affections of the skin which respond so reluctantly to the action of local remedies as does the eruption of lichen planus. This is especially the case when the disease has become chronic.

The calamine and zinc lotion is always soothing and hence advisable at the outset, or, if the itching is severe, ten per cent. of oleum cadini in zinc ointment may be frequently applied. The following lotion is recommended by Wehl:

℞ Naphtholis . . . . . 2
Glycerini . . . . . 10
Alcoholis . . . . . ad 100
M.

In more chronic cases a corrosive sublimate lotion of one-half of one per cent. strength may be used, or the following ointment recommended by Unna:

℞ Hydrargyri chloridi corrosivi . . . . . gr v 1
Acidi carbolici . . . . . gr xx 4
Unguenti zinci oxidi . . . . . ad ℥i ad 100
M.

This ointment is mentioned by most writers and generally highly praised. My own experience leads me to coincide with Kaposi, who states that he has never noticed the slightest effect from it. Crocker advises the following:

℞ Olei rosæ . . . . . ℥ xx 4
Unguenti hydrargyri ammoniati . . . . . ʒ i ad 100
M.

The use of Vlemingkx's solution as recommended in cases of acne (page 14) may be advantageously employed in lichen planus, the strength of the application varying according to the chronicity of the patches. Herxheimer paints the patches twice a week with ten per cent. of chrysarobin in traumaticin. For very obstinate papules or patches the use of the galvanocautery has been recommended, and is said to relieve the intense itching which is often present.

In the case of elevated horny patches, which are very apt to be found upon the shins, the application of pure carbolic acid has been advised. The following varnish may prove of service, if care is taken that it is not continued long enough to produce salivation:

℞ Hydrargyri chloridi corrosivi . . . . . 2
Creosoti . . . . . 4
Acidi carbolici . . . . . 10
Collodii . . . . . ad 100
M.

A salicylic acid ointment or plaster of twenty per cent. strength will remove the roughness of the patches and tend to hasten their disappearance.

Lichen planus runs an extremely variable course, some cases tending to a spontaneous recovery in a month or two, others persisting for many months, or even years, in spite of vigorous local measures. It is this uncertain course which has led many to overestimate the value of internal and local remedies which may have been followed by a speedy cure in a few successive cases of a mild type. There is no plan of treatment which will cure every case in a definite period, as has been claimed by some enthusiastic writers.

## LICHEN RUBER

Lichen ruber is a chronic relapsing disease characterized by an eruption of small reddish acuminate papules at the orifice of hair follicles. By aggregation these form rounded or elongated patches covered by fine whitish scales or marked by an exaggeration of the natural furrows of the skin. The disease was fully described by Hebra, in 1862. Since then it has been confounded with lichen planus, an entirely distinct disease, and the French school have given to it the name of pityriasis rubra pilaris.

There are three clinical forms of the disease. In the papular form there are numerous small, acuminate lesions which do not increase in size but aggregate and form patches. They are often tipped with minute scales, and the patches formed by their coalescence present a white, scaly appearance resembling psoriasis. This is the squamous form of the disease. When the scales disappear from the patches the thickened skin presents a brownish-red, leathery appearance, and the parallel cutaneous furrows are so pronounced that we have the rugous form of the disease.

The treatment of lichen ruber is usually unsatisfactory so far as internal remedies are concerned. Arsenic is the one upon which most reliance is placed. According to Brocq, no internal medication is known that is truly efficacious, but he advises, nevertheless, the cautious use of sodium arsenate. Crocker says arsenic is contraindicated on account of its tendency to increase keratinization of the tissues which is already excessive, and adds that marked aggravations have followed its injudicious use. He prefers injections of one-sixth of a grain of nitrate of pilocarpin to restore the sweat secretion. Arsenic is the main remedy of the Vienna school, and is pushed to its extreme limit in all except the manifestly hopeless cases. Köbner and others have given arsenic by hypodermic injection in lichen ruber, but this form of treatment is not usually popular with patients and is rarely necessary except in cases where the most speedy effect possible is desired. Kaposi says that after the treatment by injections he has more often observed an œdema of the eyelids, sensations of heat and burning in

the skin, intense lentiginous and chloasma-like pigment spots as well as rapid relapses, than is noted after ingestion of the drug.

The alkaline diuretics are indicated when there is much congestion of the skin and the eruption is increasing. They are particularly serviceable when the patient complains of great heat in the skin, a symptom which is often the forerunner of a fresh eruption of papules. Cod-liver oil is generally useful, especially in the later stages of the disease, when the skin is very dry and emaciation is a prominent symptom. Sherwell has found considerable benefit in the use of linseed oil, both internally and locally.

The local treatment of lichen ruber is mainly palliative, and is similar to that which would be called for in a case of general dry eczema or universal psoriasis. Baths are of great service, and those containing bran or starch have been recommended. Taylor speaks highly of warm alkaline baths, while others suggest the use of vinegar. Brocq advises the use of ten per cent. of tartaric acid in glycerole of starch. Intense pruritus is often the most annoying symptom of the disease; and in one case I found that two per cent. of oil of peppermint in almond oil was the most agreeable application among a large number which were prescribed.

The prognosis in lichen ruber is extremely grave. The fourteen cases upon which Hebra based his original description of the disease all terminated fatally, and the majority of cases, if watched for a sufficient length of time, will be found to grow worse after numerous relapses, and finally to lapse into a condition of profound marasmus.

Many cases have been reported as cured by arsenic; but, without doubt, many of these have been cases of universal lichen planus, which is very rarely fatal, and frequently tends to a spontaneous cure. Other cases have been only apparently cured, as the disease often disappears for many months with, or even without, treatment. A relapse, however, is almost certain to take place, according to my experience, and the disease goes on from bad to worse until the patient's strength is finally exhausted, and a fatal termination ensues.

## LICHEN SCROFULOSUS

Lichen scrofulosus, as the name would imply, is a papular eruption occurring among those who present other characteristic manifestations of the scrofulous taint. The lesions are follicular, pinhead-sized, of a dull red or yellowish hue, and occur in groups or circles upon the trunk.

The disease is uncommon in this country, and on account of the eruption not presenting a very striking appearance, and giving rise to little or no annoyance, it may be readily overlooked. It is most frequently met with in childhood, and is more common in the male sex. It is often associated with acne cachecticorum, and with eczema of the genital region.

The treatment of lichen scrofulosus is simple, and the eruption, although often persisting or recurring for years, is never difficult to cure. Hebra's chief reliance was upon cod-liver oil, which he gave internally to the extent of the patient's tolerance, while keeping it constantly applied to the affected skin. Kaposi recommends the oil either with or without iodine, and gives the following in tablespoonful doses morning and evening:

℞ Iodinii puri . . . . . 1
Olei morrhuæ . . . . . 1000
M.

Crocker recommends the following ointment as quite as effectual and much more pleasant than the external use of cod-liver oil:

℞ Liquoris plumbi subacetatis . . . . . ♏ xv 3
Thymolis . . . . . gr. v 1
Olei cadini . . . . . ♏ v 1
Vaselini . . . . . ad ℥ i ad 100
M.

The hygienic surroundings of the patient must be carefully looked after and a goodly supply of fresh air and proper food insured. As the general health of the patient improves under this treatment, the eruption will gradually disappear, and often with it the glandular swellings and other signs of struma which may have been present.

## LUPUS ERYTHEMATOSUS

IN this country the erythematous form of lupus is met with more frequently than lupus vulgaris, the common lupus of European countries. It occurs usually upon the face, in a circumscribed or discoid form, and, owing to the fact that it is so often located upon the bridge of the nose and adjoining malar region, it has been termed the "butterfly" or "bat's-wing" form of lupus. The patches are circular or oval at the outset, slightly reddened or purplish in hue, and covered with fine, adherent scales, which, when carefully removed, often show prolongations upon the under surface corresponding to the orifices of the sebaceous glands. The disks may be somewhat depressed in the centre, and when of long standing present a peculiar pitted or worm-eaten appearance.

The disease runs a very slow course, as a rule, and the rounded lesions may coalesce and form irregular, roughened patches upon the face, scalp, and, occasionally, upon other portions of the body. In rare instances the hands, arms, and, indeed, the greater portion of the body may be the seat of the disease.

While lupus erythematosus is regarded as a tuberculous affection by such eminent authorities as Hutchinson, Jamieson, Boeck, Besnier, and Hallopeau, and clinical observation shows its frequent coexistence with various undoubted symptoms of tuberculosis, it must be admitted that the tubercle bacilli have never been found in the affected skin. Bacteriological researches have failed to give any positive results, and all attempts to inoculate animals have been unsuccessful. In view of these facts, many others regard the disease as entirely distinct from lupus vulgaris, and quite independent of tuberculosis.

The treatment of erythematous lupus is so often unsuccessful that

the disease has been regarded by some as the opprobrium of dermatology. Not all cases are rebellious to therapeutic measures, and occasionally the disease is seen to disappear spontaneously. But most cases of long standing are obstinate, and even the most vigorous measures fail to accomplish any brilliant result.

A general tonic treatment may be useful in some cases, although not curative, and when impaired nutrition is evident, cod-liver oil and the compound syrup of the hypophosphites will be found of great value. But a large proportion of patients seem to be as strong and well as the average physician who is called upon to prescribe for them, and some of the ordinary alcoholic tonics are apt to flush the face and do more harm than good. In cases where the patches are highly congested, better results can be obtained by the use of laxatives, diuretics, and remedies which control the heart's action and tend to lessen cutaneous congestion. Brocq recommends ergotine, belladonna, quinine, digitalis, hamamelis, and aconite.

Arsenic has been used by many on the recommendation of Hutchinson, but it is very doubtful if others have been successful in curing their patients through its use.

Phosphorus has been highly praised by Anderson and Bulkley, and good results reported, but, as Piffard remarks, "the remedy is a two-edged sword that must be handled with great circumspection."

Iodide of starch, recommended by Anderson, may benefit the patient, but is not likely to influence the eruption in any notable degree. Cases have been reported by Besnier as cured by the internal use of iodoform, but this plan of treatment does not seem to have found favor with many others.

Quinine is a remedy which has apparently cured some cases, and which certainly seems to have a direct and decided effect upon the eruption. I have seen some cases aggravated as well as improved by its use. Unna and Morris give ichthyol internally and claim that it tends to lessen the hyperæmia of the patches.

The local treatment of erythematous lupus must vary according to the

character of the eruption. Much harm frequently results from the use of applications which simply irritate and cause the eruption to spread. In the early stage of the disease, and also in chronic cases when there is much congestion of the patches, a soothing or mildly astringent lotion is apt to prove of the greatest service. The "lotio alba," used so frequently in the treatment of acne (page 13), has often a marked effect in lessening the congestion and improving the appearance of the patches. The frequently repeated and long-continued application of spirit of camphor is a simple method of treatment, superior to the ointments commonly used, and in acute cases is worthy at least of a trial. Strong alcohol alone has been found to be of decided value in many cases, including those of long standing.

When the patches are dry and scaly, vigorous friction with soap in alcohol (linimentum saponis mollis c. s. P.), followed by the application of mercurial plaster, has been highly recommended by foreign writers. I have seen improvement follow this plan of treatment, but have never known it to cure a case.

An ointment or plaster of salicylic acid, gradually increased in strength until the inflammatory reaction is as great as the patient will tolerate, is one of the best applications to chronic patches. Brocq speaks highly of the following formula:

℞ Acidi salicylici . . . . . 5
Acidi pyrogallici . . . . . 10
Vaselini . . . . . ad 100
M.

This may be used at the outset and superseded later by a twenty per cent. or even stronger ointment of salicylic acid in lanolin. Although this will do much good in carefully selected cases, it will as certainly do harm in most cases taken at random. Other drugs, such as chrysarobin, naphthol, iodine, and resorcin, may also be used to advantage, but I cannot indorse the suggestion of Bowen that all the stimulating agents should be tried in rotation. When a decided improvement follows a change from one stimulant to another, it is usually a coincidence due to some

cause entirely apart from the local treatment and cannot be expected to occur in the treatment of another case.

Superficial cauterization and scarification of the patches have proved of little value in my experience. The same may be said of electrolysis. If the patient is anxious to have the patches removed in the shortest possible time, and will not hold his physician responsible for a resulting cicatrix, the curette or the thermo-cautery, or a combination of both, is capable of effecting the desired result.

The application of liquid air will destroy the vitality of the morbid tissue very quickly and cause a curative ulceration. In my service at the Vanderbilt Clinic this remedy has been tested during the past year, and one patch of erythematous lupus was quickly destroyed by its use. But the pain occasioned during and shortly after its application, and the depressed scar resulting after healing of the ulceration, would not lead me to recommend this novel therapeutic method.

## LUPUS VULGARIS

Lupus vulgaris is one of the forms of cutaneous tuberculosis. The eruption consists of disseminate or aggregated nodules which tend to soften and ulcerate. A chronic patch therefore usually shows more or less cicatricial tissue in the centre, while new lesions are slowly developing at the border. The disease runs a very slow course, in strong contrast with the nodular syphilide, to which the eruption may bear a strong resemblance. It is common in youth, and through neglect or ineffective treatment often persists during middle life and even in old age.

The face is the most common seat of the disease, and in time a frightful appearance may be occasioned by its ravages. The nose is often destroyed, the eyelids and lips drawn apart from loss of tissue or puckered into narrow slits from ulceration and contractile cicatrization. The external ear is often destroyed and a mere orifice left, and even this may be occluded by the disease. Lupus of other parts is comparatively rare, but

large patches, often of a serpiginous character, may be found upon the trunk or extremities. The mucous membranes of the nose and throat are often simultaneously affected.

Lupus is a local disease, resulting without doubt from accidental inoculation of the skin with the *bacillus tuberculosis*. It is never hereditary, but the children of tuberculous parents and others who are weak, delicate, and poorly cared for are most likely to become infected.

The treatment of lupus vulgaris is mainly of a surgical character, and three ends which should be sought are (1) the removal of the morbid tissue, (2) with as little pain as possible, and (3) with the least resulting disfigurement.

One of the oldest remedies in the treatment of lupus, and one still recommended by some surgeons, is the knife.

This will certainly remove the disease when limited in extent, and with the modern improvements in skin-grafting, a patch of lupus of almost any size might be excised and the wound healed. But this cannot be accomplished without much dread and discomfort on the part of the patient, and where a plastic operation on the face is involved, the result is seldom satisfactory from a cosmetic point of view. The prevalent fear of the surgeon's knife may be irrational, but it exists, nevertheless, and, in spite of the favorable results reported by Hahn, Senger, and others, in no case of lupus, large or small, is excision, in my opinion, preferable to other methods of treatment at our command.

The cautery, as commonly employed, is another agent, which I would unhesitatingly condemn. Acting equally upon healthy and diseased tissue, it must either produce an unnecessarily deep ulcer, or else the smooth, superficial, and delusive cicatrix will soon appear studded with isolated nodules. Whether a Paquelin or galvano-cautery be used, the operation is generally painful and the result either uncertain or disfiguring.

Doubtless the best method of employing heat in the treatment of lupus is that advocated by Besnier. This method consists in making punctate and linear scarifications by means of variously shaped needles, knives, and

buttons of platinum, connected with a galvano-caustic battery. The use of the flat electrode may be successful in the destruction of lupus tissue, but the time required to effect the result is so great as to render the method of comparatively little value.

The curette is an instrument well deserving the high reputation it has acquired in the treatment of lupus. When used alone it is apt to prove insufficient to effect a cure. It usually removes the greater portion of the diseased tissue with ease, and when cocaine is injected or even applied on pledgets of cotton to the raw surface, a large patch may be scraped with but little pain or discomfort to the patient. The healthy tissue remains uninjured, and a wound is left, which, properly dressed, will heal speedily and leave a smooth cicatrix. The size and shape of the curette is largely a matter of taste, but the form of the Volkmann spoon can hardly be improved. For recurrent isolated nodules appearing in the cicatrix after a previous unsuccessful operation, and for the minute points of diseased tissue noted after multiple scarification, even the smallest curette is apt to prove too large.

A dental burr or a dental excavator can be used in such a case to great advantage. Indeed, whenever lupus appears in the form of disseminated nodules, burrs of varying size will be found greatly superior to a small curette. With such an instrument many small and deeply seated nodules of lupus can be bored out which would escape the action of any scraping process. A rotary movement of the instrument should be made by rolling the handle between the thumb and fingers, or a motor may be used which can be worked either by electricity or foot power. The burr should be dipped in pure carbolic acid before it is pressed into a nodule or mass of lupus tissue, as this tends to increase its destructive action while lessening somewhat the painful sensation.

Since recommending the use of the dental burr many years ago in the "Journal of Cutaneous and Venereal Diseases," I have used it many times and with the greatest satisfaction. Mr. Morris, of London, has devised a similar instrument for this purpose, claiming advantages over the burr

(obtainable from any dental instrument dealer) which seem to me theoretical rather than practical.

As regards scarification in the treatment of lupus, too much, I think, has been said in its favor, while the objection raised against it, that it promotes the absorption of bacilli and leads to pulmonary tuberculosis, is largely hypothetical. Linear scarification, as advocated by Squire and Vidal, is certainly an improvement upon the punctiform scarification employed by Dubini, Volkmann, and Veiel. There is no doubt but that it will cure lupus in most cases, and leave the most satisfactory cicatrix, but this method of treatment involves usually an amount of time and patience which greatly lessens its value as a therapeutic measure. The only cases in which it is superior to other plans of treatment are those of ulcerating lupus of the nose. Here the curette and various applications which will remove the diseased tissue are liable to produce considerable deformity, and cause the patient to go through life with a misshapen or stumpy nose. Scarification, however, in such cases, while it gradually destroys the lupus, permits a new growth of connective tissue to take its place, which tends to preserve the size and form of this important feature. As Vidal has shown by microscopical observation, the lupus cells gradually alter their configuration and assume the shape of fibres of connective tissue, and, as Squire has claimed, the nose may often be actually rebuilt.

Of caustics and various applications which tend to destroy lupus tissue by virtue of their chemical effect, a long list might be given. All have proved of service in certain cases, few have manifested any remarkable and distinctive therapeutic value, while none have as yet found their way into general favor. I will merely mention nitrate of silver, caustic potash, chloride of zinc, lactic acid, ethylate of sodium, iodoform, and aristol, and remark that, in spite of time-honored usage or eminent recommendation, they possess no special value in the treatment of lupus.

The use of bichloride of mercury, on account of its bacillicide properties, has been advocated by Doutrelepont, Tausin, White, and others.

My own experience with this method of treatment has proved unsatisfactory, and the slight improvement which took place in a few cases appears to have been due to a stimulating effect such as would follow its application to the nodules of acne or rosacea, rather than to any parasiticide action. The reported experience of others has been similar to mine.

For many years I have used a strong ointment of pyrogallol, varying from twenty-five to fifty per cent. The application is sometimes quite painful for the first twenty-four or forty-eight hours, and may give rise to considerable inflammation of the part. But the continued use of the ointment soon produces a benumbing sensation in the locality to which it is applied, and no further complaint of pain is made until the ointment is discontinued and a simple dressing is substituted. This application, coinciding with the separation of the sloughing tissue, will often be regarded by the patient as more painful than the pyrogallol. When the dirty, brownish, pultaceous slough has separated and left a clean, raw surface, mercurial plaster may be applied, beneath which the ulcer will become converted into a smooth, pliable cicatrix. Or, if the raw surface be considerable in extent, Thiersch's method of skin transplantation may be employed with benefit. I have no hesitation in recommending this use of (1) the curette, (2) the strong pyrogallol ointment, and (3) the mercurial plaster as a most admirable method in the treatment not only of lupus but of rodent ulcer. It is a method which has many advantages and few objectionable features.

Salicylic acid is a remedy which experience has proved to be of service in the treatment of lupus and other forms of cutaneous tuberculosis as well as in many other affections of the skin. Unna advocates its use in most enthusiastic terms. He recommends the application of varying strength, but all containing two parts of beech tar creosote to one part of salicylic acid. The pain caused by the acid alone is very severe, and constitutes a serious objection to its use, but it is greatly mitigated by the anæsthetic action of the creosote, which Unna speaks of as the "morphine of the skin." The creosote has an antiseptic and bacillicide effect, and is therefore both corrigent and adjuvant to the salicylic acid. A strong plaster is at first applied

to destroy the epidermic covering of the lupus tissue. Before the second plaster is applied to the raw surface, a solution of cocaine may be employed, which will temporarily deaden the pain, which in a short time yields to the more lasting anæsthetic effect of the creosote.

Recently a number of new methods have been advocated for the cure of lupus. The phototherapy of Finsen consists in focussing the chemical rays from the sun or an arc lamp upon the affected patch. It has been successfully employed in a number of reported cases, but a treatment which involves a daily sitting of an hour, continued for many months, is too tedious to warrant the praise which has been bestowed upon it. In a case of lupus of long standing I have recently had the right side treated by phototherapy, while the left side, which was somewhat more affected, was treated by means of the burr and carbolic acid in the manner already described. After twenty sittings for each side, the right showed little or no change, while the left (or worse side) had become smooth and presented little if any sign of disease.

The Roentgen ray treatment has also been employed and good results obtained; but, like cauterization with a fine stream of hot air, as advocated by Holländer, or freezing with a spray of liquid air, the treatment is one which cannot be considered of superlative merit until others have confirmed the statements of its enthusiastic pioneers.

The constitutional treatment of cutaneous tuberculosis may be conveniently divided into the specific and non-specific, the former aiming at a direct action upon the morbid growth, the latter merely improving the general condition of the patient, and thereby modifying the soil upon which the tuberculosis is implanted.

Despite the vagueness of the term, there is certainly such a thing as scrofula. It is an inherited or acquired condition of certain tissues, which leads to the development of definite and characteristic symptoms. It doubtless renders the subject of this diathesis especially liable to the engrafting of tuberculosis in the strict sense of this term. Although no one can assert that cod-liver oil, or iodine, or the hypophosphites have ever produced the slightest direct effect upon lupus or other tuberculous lesions, there is no

question as to the value of these remedies in combating the scrofulous diathesis. In the therapy of cutaneous tuberculosis, these remedies may therefore be justly considered as prophylactic, and clinical observation has repeatedly shown that in certain cases they are a valuable and often indispensable adjuvant to local measures. Experience teaches the value of iodide of starch as a reconstructive agent in all cases of struma, whether tuberculosis be present or not. In 1880, McCall Anderson advocated the use of this remedy in erythematous lupus, and, strangely enough, implied that it was of no value in lupus vulgaris. His formula consisted of twenty-four grains of iodine to an ounce of starch, the iodine to be triturated with a little water, and the starch to be added slowly, the mass to be dried by a gentle heat, and kept in a close-stoppered bottle. By use of this remedy, he claimed that the largest amount of iodine could be most easily introduced into the system. I have used this remedy, freshly prepared, with great satisfaction, and I think with great benefit, not only in cases of lupus vulgaris, but in many cases of acne occurring in lymphatic subjects, and also in cases where chronic syphilis is combined with struma.

For the specific treatment of cutaneous tuberculosis, various plans have been advocated, but the method promulgated in 1890 by Robert Koch is the only one which seems worthy of discussion.

In both Europe and America a remarkable diversity of opinion has been expressed as to the value of lymph injections in the treatment of cutaneous tuberculosis. The unbounded enthusiasm which greeted the introduction of this new method ten years ago has completely subsided, and many who were then ready to pay fabulous prices for a few drops of the lymph are now busied with newer remedies and find no use for tuberculin.

My own experience has led me to the belief that tuberculin exerts a specific action on lupus tissue, and is of great value, not only as a diagnostic test, but as a remedial agent. The new tuberculin now prepared for professional use, though inferior to the old preparation for diagnostic purposes, may be employed with less danger of unpleasant symptoms, and with equal efficacy.

## MILIARIA

Miliaria is a disease resulting from obstruction of the perspiratory ducts. It may occur under two clinical forms: Miliaria crystallina (sudamina) and miliaria rubra (prickly heat).

The minute drops of sweat which collect in the spiral ducts of the perspiratory glands as they pass through the epidermis, cause an eruption of numerous discrete transparent vesicles, which appear like drops of dew upon the chest or abdomen of patients suffering from acute rheumatism, pneumonia, typhoid, or one of the eruptive fevers.

A dusting powder of starch, or some other absorbent, is the only treatment required.

The fine red rash, either vesicular or papular in character, which appears upon the trunk as a result of heat, friction of clothing, or excessive perspiration, constitutes the inflammatory form of the disease known as miliaria rubra. The obstruction of the sweat duct may be either a cause or a result of the inflammatory condition.

In adult life the eruption (formerly called lichen tropicus) is liable to appear during the hot summer months, and affects those who perspire excessively from over-exertion or too warm clothing. It is especially apt to be noted in those who are in poor health, who bathe infrequently, who drink much beer or spirits, and who have a weak circulation. This "prickly heat," as the eruption is commonly called, often develops suddenly and is attended by an intense burning sensation, which is at times intolerable. It bears a slight resemblance to acute papular eczema, but its sudden occurrence in connection with profuse sweating, its rapid course, its sensation of burning rather than of itching, the minuteness and discreteness of the lesions, and the absence of tumefaction and of moist patches will form a basis for differential diagnosis.

In the treatment of prickly heat, cold bathing, light clothing, and a few hours of perfect rest will usually give great relief, and often effect a

cure. To lessen the congestion of the skin, an alkaline diuretic—such as the granular effervescent citrate of potash—will often prove of benefit.

In the local treatment, lotions or dusting powders may be used. Lime water, or a two per cent. solution of sulphate of copper, is doubtless as beneficial as any other lotion, while plain starch or talcum powder will probably act as well.

## MILIUM

The rounded whitish tumors of the size of a millet seed often seen upon the cheeks, temples, and eyelids are called milia. They are caused by an accumulation of sebum in glands seated just beneath the epidermis, the ducts of which have become obliterated. They may be few or numerous, and often remain for years unchanged in appearance, and giving rise to no discomfort. Sometimes they aggregate, become dry and hard, and appear like cutaneous calculi.

The treatment of a milium consists in removing the minute seed-like mass with as little injury to the skin as possible. This may be done by puncturing the epidermis obliquely, or almost horizontally, above the little tumor, with a triangular acne lance or any knife with a fine, sharp point. The white, rounded, cystic mass may now be picked out upon the point of the knife. If this little operation is done with extreme care and the requisite amount of skill, not the slightest bleeding is occasioned, and no trace of the puncture is left.

Some writers speak of opening each one of the little pearly masses, squeezing out the cheesy sebaceous matter, and cauterizing the sac with a point of nitrate of silver or a drop of tincture of iodine. Such harsh treatment would produce a most undesirable, though not a permanent, disfiguration, and for facial milia is quite unnecessary. In case of large milia upon the scrotum, which resemble small wens, this method of treatment may be satisfactorily employed.

The use of the electrolytic needle has been suggested in the treatment of milium, but removal by puncture is much more speedy and desirable.

## MOLLUSCUM

Molluscum is a name applied to a small, superficial, globular, or flattened tumor of epithelial character. The names molluscum contagiosum and molluscum epitheliale are used by some writers, but the adjectives are quite unnecessary. Since the disease formerly called molluscum fibrosum is now generally known as fibroma, there can be no danger of confounding simple molluscum with any other disease through ambiguity of nomenclature. The molluscous tumors, which may occur singly or in numbers, contain semi-solid cheesy contents, which can be readily pressed out from the summit, or from a central umbilication which is usually present. They are most frequently seen upon the face (particularly on the eyelids), the neck, and the genitals. They are usually of the color of the surrounding skin, but may become inflamed and reddened, especially when two or three are closely aggregated. The larger tumors are apt to become pedunculated.

A considerable difference of opinion exists as to the cause of molluscum: some regarding the tumor as the result of a parasitic infection of the skin. It is certainly contagious in a mild degree, and sometimes spreads among children in a school or asylum. In a large proportion of cases, the hands of the patient will be found to be the seat of ordinary warts. Although the disease occurs with much greater frequency among the poorer classes, it cannot be considered as the offspring of poverty and uncleanliness. Damp and crowded dwellings may favor its development, and I have known a number of cases to occur in such a locality. Ill health is not always a factor in its production, for while most of the molluscous children I have examined were strumous or weakly, there have been some upon whose faces not even the dirt could conceal the glow of health.

The treatment of molluscum consists in removing the tumor with as little inconvenience to the patient, and as little injury to the skin, as is possible. In the case of adults and many children, it is a simple matter

to shave off the tumor, with a scalpel or any thin-bladed knife, upon a level with the surrounding skin. For tumors on the eyelids a pair of fine curved scissors can be used to advantage. The slight hemorrhage may be quickly checked by touching the cut surface with a stick of nitrate of silver. A large pedunculated tumor ligated with a silk thread will speedily shrivel and fall.

The use of the dermal curette is doubtless the simplest and speediest method of removing the tumors, especially when they are numerous and widely scattered. In most localities affected by molluscum the skin can be drawn tense by pressure of the thumb and fingers, when one or two quick lateral strokes with a small and rather sharp curette will readily erase the growth. It is unnecessary to apply nitrate of silver with a view to preventing a return of the growth, for this is quite unlikely to occur after curetting. But the application of the silver stick is advisable, since it will serve to check the hemorrhage at once and cover the wound with an excellent plaster. Another simple plan is to bore into each lesion with a burr dipped in carbolic acid as recommended in the treatment of the nodules of lupus. The use of nitric acid, or the acid nitrate of mercury, which has been suggested, is uncalled for, and might tend to the production of a scar. Pinching the tumor between the blades of epilating or other forceps will usually set up enough inflammation to destroy the growth and prevent its return.

In the absence of a curette or forceps, the plan, suggested by Kaposi, of squeezing out the contents of the tumor between the thumb nails will also attain the desired end.

The application of sulphuric, mercurial, and other irritating ointments has been recommended, especially in cases where the mollusca are numerous. This method of treatment is efficient, but unnecessarily slow in effecting a cure.

Owing to the superficial location of the growth, no scar should be left after treatment. But when one or more tumors have suppurated, as occasionally happens, the crust which forms may be scratched by the child and a slight pit result.

## MORPHŒA

MORPHŒA is regarded by many writers as a circumscribed form of scleroderma. Pathologically the two affections are closely related, but clinically they are quite distinct. In a few reported cases the peculiar features of each have been present.

In its typical form the disease is characterized by one or more whitish, indurated, circumscribed patches of various size and shape. They are usually surrounded by a narrow zone of a faint lilac hue, and upon the extremities often appear in a line following the course of a nerve. The surface of the patch may be smooth and of the color of old ivory, but generally it is dry and wrinkled and usually of a dirty-white hue.

Patches of morphœa may remain for months or years without perceptible change, and then gradually disappear, leaving a normal or an atrophic condition of the skin. The band form of the disease, described by some writers, has not, according to my experience, presented the characteristic features of morphœa, but has seemed like a case of simple linear atrophy, following the course of a nerve.

The cause of the disease is unknown. While mental anxiety and nervous depression, on the one hand, and various forms of local irritation and injury have seemed in some cases to be possible etiological factors, the disease develops in the majority of cases without any apparent cause.

In the treatment of morphœa, a good result is to be hoped for rather than promised. Time and patience are always necessary in carrying out any therapeutic method, and in my experience the patient usually becomes discouraged and inclined to stop all treatment long before any definite result is attained.

No benefit has ever resulted from the administration of arsenic or

other internal remedies, so far as reports of cases show. Local treatment may prove of some slight service, though incapable of producing any brilliant results. Hyde remarks that, considering the favorable issue in the majority of untreated cases, and the ill consequences of over treatment in others—namely, the production of irritation—one should look with caution upon all local management of the disease. Since the patch is largely due to local obstruction of the blood vessels and lymphatics, any form of treatment which will tend to improve the general circulation is likely to do good. Cold bathing and daily massage are, therefore, to be recommended.

The galvanic current has been used in many cases, and improvement, if not a cure, has resulted. Crocker suggests that it should be applied in the neighborhood and not over the patch, as anything that irritates the diseased area induces further thickening. Allen reports favorable results from the use of electrolysis. Brocq believes that the disappearance of patches may be hastened by a combination of the following measures: 1. The internal use of iodide of potassium in doses of fifteen to thirty grains; 2. Electric baths; 3. Electrolytic puncture twice a week with a current of from eight to fifteen milliamperes, lasting twenty seconds; 4. Application of mercurial plaster, and 5. Thermocautery to spine once a week, at point of emergence of nerves supplying the affected part.

## MYCOSIS FUNGOIDES

Mycosis fungoides is a chronic and, so far as present experience goes, an incurable disease. It presents a variety of clinical appearances, and in its early stage may be mistaken for erythema, eczema, psoriasis, or some other inflammatory disease. In time, however, and in some cases at the very outset, characteristic fungoid tumors appear which are unmistakable.

In the pre-fungoid stage, erythematous discs, circles and semicircles, or infiltrated scaly patches, with a sharply defined margin, are usually present. Itching is a prominent and distressing symptom which is rarely absent.

The lesions may subside and entirely disappear for a time in some cases, but treatment seems to have very little effect in causing their removal.

The tumors which may develop at any time in the course of the disease vary in size and shape, and are rarely persistent. Some will disappear rapidly while others are developing. Some are rounded and elevated, while others are flattened, and by healing in the centre form rings or gyrate patches. Pigmentation of the skin is common, and both superficial and deep ulceration frequently occurs. As the disease increases in severity, the strength of the patient lessens, and death results in a few months or years.

The disease is probably of an infectious nature, but the immediate cause is uncertain. It is considered by many to be closely allied to general sarcoma.

The treatment of mycosis fungoides can only be palliative, since a fatal termination is almost certain. The internal use of arsenic has been thought by some to have a beneficial effect. Doutrelepont reports improvement in advanced cases under arsenical treatment, but Kaposi has seen no effect from this method. In cases in which I have used this drug, both by the mouth and by hypodermic injection, no good result has been attained. A nutritious diet, with strychnia, will often tend to improve the patient's condition, and morphia in the later stages is advisable.

The local treatment should be directed to the relief of the pruritus and to general antiseptic measures. Frequent baths and the application of a strong carbolic lotion will fulfil each of these indications. Excision of tumors is unnecessary, unless they have attained a very large and uncomfortable size. When ulcerated surfaces are present, they may be dusted with aristol powder, or the following, as suggested by Brocq:

℞ Pulveris camphoræ . . . . . 5ß
Naphtholis . . . . . ad 100
M.

Morris mentions a case in which considerable local improvement followed the use of resorcin ointment (gr. xx to ℥i).

## NÆVUS PIGMENTOSUS

A pigmented nævus or mole occurs in its simplest form as a small yellowish-brown or blackish patch, and results from an excessive deposit of pigment in the skin (nævus spilus). It may be single or numerous, and is usually of small size, differing from a freckle (lentigo) in being permanent. In some cases the pigmented nævus is raised, and presents a rough, fissured, and warty surface (nævus verrucosus). The surface presents occasionally an aggregation of small rounded fibrous tumors (nævus papillomatosus). There is sometimes a foul-smelling secretion from a verrucous or papillary nævus, and such a growth may become the seat of malignant disease. A pigmented nævus is often covered with fine or coarse hair (nævus pilosus.)

The treatment of a pigmented nævus depends upon its size and character. The small smooth nævus may be permanently removed by any caustic which will destroy the epidermis and the superficial portion of the corium. Corrosive sublimate, ethylate of sodium, trichloracetic acid, and lactic acid have been recommended for this purpose. Any blistering agent will remove the pigment temporarily, but the dark color returns in a short time if only the epidermis is removed.

The smooth pigmented nævus upon the face of children can best be treated, according to my experience, by dotting the surface carefully with nitric acid applied by means of a wooden toothpick. Care should be taken that the minute yellow dots caused by the action of the acid should not coalesce and produce ulceration. The little crusts which form will fall in a week or ten days, and repeated application of the acid will remove the dark spot, leaving no permanent scar, or one so slight as to be scarcely noticeable.

The verrucous form of nævus can best be treated by a more free use of acid or by the electrolytic needle. The growth cannot be removed and a perfectly normal skin left by any method of treatment, and the patient should understand in advance that a slight and inconspicuous scar is the best result attainable in such a case.

## NÆVUS VASCULARIS

Nævus vascularis is the result of a permanent dilatation and increased growth of the cutaneous blood-vessels, and is usually congenital. In its simplest form it occurs as a small red punctate lesion with a few capillary vessels running from it in various directions (nævus araneus). In the form commonly known as "wine mark" it appears usually upon the face, and presents an irregular patch of a hue varying from bright pink to dull purplish red (nævus flammeus). It is unilateral in most cases, and has been known to extend over one half of the body. Small tumors of a cherry or grape color sometimes develop upon the surface of a wine mark, or independently. In infancy such growths often tend to increase rapidly in size (nævus tuberosus). A subcutaneous vascular growth of venous character often involves the skin and forms a large compressible tumor of a faint bluish tint (nævus cavernosus).

The treatment of the vascular nævus depends upon its size and character. In the punctate form often seen upon the faces of children as well as adults, the use of the electrolytic needle is without doubt the very best method of obliterating the dilated vessels. With a current of two or three milliamperes so little pain is occasioned that most children can be induced to bear it for a few seconds by a promise of candy or other reward. The needle attached to the negative cord must be sharp and quickly introduced into the centre of the red spot. The sponge electrode attached to the positive cord should now be gently and slowly pressed against the palm. The effect of the electrolytic action will be noted in the gradual blanching of the tissue around the needle. When this is withdrawn, there should be no hemorrhage if the current has been of proper strength and continued for a sufficient length of time to occlude the dilated vessel. The small vascular tumor often seen upon the scalp or face of an infant may be destroyed by nitric acid or the galvano-cautery.

The treatment of wine mark has long been and is still considered by many as a hopeless task. From time to time new methods have been

recommended with more or less enthusiasm, but none has as yet been found capable of producing any brilliant therapeutic result. The most that can be said is that a wine mark can be greatly improved in appearance, if not satisfactorily removed, and the more disfiguring the mark the more successful will be its treatment.

Cauterization will readily destroy any wine mark if vigorously employed, but the scar which is apt to be left would generally be considered more disfiguring than the mark itself. Nothing short of a miracle will remove a large vascular nævus and leave a perfectly normal skin. The main object of treatment should therefore be to destroy the new growth of vessels with the least injury to the skin.

In the small red patches upon the face of children, and in the light-hued nævi of older patients, the safest and least painful application which is likely to do good is pure carbolic acid. This should be applied with patience and persistence to limited portions of the red area and at intervals of one or two weeks, in order to give time for the outer layer of skin to peel and leave a smooth surface. The acid can be used in drops to dot the affected skin, or applied in the form of stripes running across the patch. Care should be taken not to cover too large a portion of skin, as some susceptible patients are apt to become dizzy, or even intoxicated, from absorption of the acid. Ethylate of sodium and various powerful acids are more effective in destroying the dilated vessels, but, at the same time, are more likely to cause ulceration and subsequent roughness of the skin, even when employed with the utmost care and skill.

The operation of linear scarification as proposed by Squire consists in first freezing a portion of the affected skin by means of ether spray and then making parallel incisions with a thin scalpel or an instrument composed of a dozen or more blades and called the "multiple scarifier." The cuts should be no more than a sixteenth of an inch apart, and as long as they can be made quickly and straight. The bleeding is slight if the cuts are not over a sixteenth of an inch in depth, and can easily be arrested by applying a piece of blotting paper with slight pressure. This

piece of paper should be gently peeled off before it has dried, and in the direction of the incisions. Squire says: "If the little operation be executed cleverly, that is to say, if the skin is well frozen, the instrument exquisitely sharp, the incisions made with perfect regularity of spacing and with uniform equality of depth, and a special care be taken to avoid any accidental dragging of the strips apart, so that no clot is formed in the incisions; if such details be well cared for, it will be found that the cuts heal with surprising rapidity, and become within a few days quite invisible. The process of scarification must be many times repeated, at intervals of a few days—that is to say, as soon as the last cuts are healed. At each operation the direction of the parallels of the second operation should be oblique to those of the first operation, and so on. The process is a tedious one, but the result of it is highly satisfactory, for the stain is made to disappear without the production of a scar."

This operation appears to have failed to accomplish the desired result in the hands of others, and my own limited experience with it leads me to the belief that it is inferior to treatment by electrolysis.

An operative procedure recommended by Frederick Churchill, of London, ("Face and Foot Deformities," 1885,) consists in puncturing the skin with the needle cautery and thereby causing the formation of hundreds of microscopic equidistant scars vertical to the surface. A coating of collodion is spread over the portion of the nævus which is to be operated upon, and a thin metal plate perforated with holes about one-eighth or one-fourth of an inch apart is firmly pressed upon this hardened surface. With a series of rapid punctures through the skin the effect of arresting the blood current in the dilated vessels is attained. A square inch may be treated at one sitting, and the skin covered with a carbolic oil dressing. In a case illustrated by two chromo-lithographs a notable improvement is shown in the condition of a girl's face, but as this result involved a weekly operation under anæsthesia for a space of three months, the method of treatment seems hardly worthy of approval.

The treatment of vascular nævus by electrolysis is one which I have

employed during the past twenty years, with results of a more or less satisfactory character. Although it has not accomplished as much as might be desired in the removal of wine mark, it is certainly of much greater service than the methods advocated by Squire and Churchill. Its object is to create numerous minute cicatrices upon the surface of the purplish patch, which will tend to reduce the color of the nævus to such a degree that it will present comparatively little contrast with the surrounding skin. I have often used an instrument containing a dozen or more needles, with points upon the same plane and about two millimetres apart, but a single needle attached to the negative cord of a galvanic battery, such as is used in the treatment of hypertrichosis (page 109), will answer the purpose.

Wine mark has been treated by Sherwell by means of a cluster of needles dipped in pure carbolic acid and thrust into the skin. While this may prove more or less successful in destroying the superficial vessels, and thereby lessening the dark hue of a nævus, it is certain that the galvanic current is more active and at the same time more manageable than acid adhering to the point of a needle, and better adapted to produce the speediest results and with the least injury to the surface of the skin.

## ONYCHIA

Onychia, or paronychia, is a term which implies an inflammatory condition of the matrix and soft parts adjoining the nail. In most cases the fold of skin rising above the lateral border of the nail is the part affected (onychia lateralis), but the root of the nail or underlying tissue may be the seat of the inflammation. An augmentation or deformity of the nail substance often takes place, and loss of the nail with more or less ulceration is a common result.

Onychia may be idiopathic and occur alone or in connection with an eczematous condition of the finger ends. It is frequently traumatic in its origin, and may result from a cut, prick, or blow upon the fingers, or from the pressure of a tight shoe upon the toe nails. It may be due to the growth

of a parasitic fungus (onychomycosis) and occur with patches of favus or ringworm upon the scalp or other parts of the body. As a rule, however, parasitic nail disease occurs alone, and its origin is apt to be unaccountable. In early syphilis onychia is not uncommon, and in most cases only one finger is affected. In a severe form of variola it may also occur.

A malignant form of onychia of tuberculous character sometimes occurs in strumous children, runs a chronic course, and results sometimes not only in the loss of the nail, but of the terminal phalanx of the finger.

Onychia lateralis most frequently affects the great toe and constitutes a painful and annoying affection. From the pressure of tight shoes the external border of the nail becomes unduly curved, and the swelling of the soft parts in the immediate vicinity produces that chronic condition which is commonly known as "in-growing toe nail."

The treatment of onychia depends upon the condition and upon its cause. The occurrence of inflammation about the nail as a result of injury may be avoided to a certain extent by the immediate immersion of the finger in very hot water. When a spontaneous paronychia is threatening, the progress of the inflammation can sometimes be checked by painting the reddened and slightly swollen skin with a twenty per cent. solution of nitrate of silver. When the inflammation is moderate, a strip of salicylic acid plaster (10 per cent.) bound tightly around the nail may prove of service. When suppuration has taken place a deep incision is called for, and when there is ulceration the best method of treatment is the constant application of iodoform ointment.

In syphilitic onychia the internal treatment of the disease supplemented by strips of mercurial plaster applied locally will soon effect a cure, and the nail, when lost, will usually grow again without deformity.

In the treatment of parasitic onychia the affected nails and surrounding parts should be softened by immersion of the fingers in water as hot as can be borne, or in equal parts of liquor potassæ and rose water. A one per cent. lotion of corrosive sublimate should now be applied to the nails by means of a nail or tooth brush, and this repeated several times a day. If

the skin becomes irritated by such vigorous treatment the applications must be weakened or discontinued and the fingers immersed for a half-hour at a time in a saturated solution of hyposulphite of sodium.

The management of in-growing toe nails often demands much care and skill. The corner of the nail should be pared back as far as possible after it has been thoroughly softened by a prolonged foot bath, or carefully raised and a thin piece of lead or folded strip of linen pressed beneath it. The soft part may be drawn away from the border of the nail by the traction of narrow strips of adhesive plaster carried under the toe. A broad, square-toed shoe or slipper must be worn until the inflammation subsides.

## PAPILLOMA LINEARE

This disease is described by many writers under the name of ichthyosis hystrix, although it is never associated with ordinary ichthyosis, and is entirely distinct in its nature. Nævus unius lateris, nerve nævus, and papilloma neuroticum are other names which have been applied to the warty growth. It usually affects a limited portion of the body, is frequently unilateral, and the unaffected skin presents a normal appearance. The streaks of warty projections follow the direction of the cleavage lines of the skin, and incidentally may follow the course of certain cutaneous nerves for a distance. They run transversely upon the trunk and longitudinally upon the extremities. The growth is often seen traversing the gluteal region and posterior thigh or running along the anterior forearm and palm.

The treatment of this disease is entirely local. When it appears as a faint line of grayish, flattened, warty elevations, a twenty per cent. ointment or plaster of salicylic acid will often suffice to effect its complete removal. When there are numerous lines of dark horny masses projecting considerably above the surface of the skin, treatment of a surgical nature is usually required. The curette may be used in some cases with success, as in the case of ordinary warts, but often the papillomatous prominences are dense and fibrous, and abscission with sharp, curved scissors must take the place of curetting.

## PEMPHIGUS

Pemphigus (from the Greek word πέμφιξ, a bladder) is a disease characterized by an eruption of blebs, or bullæ. But all eruptions of a bullous character are by no means to be regarded as cases of pemphigus. While bullæ appear incidentally in syphilis, leprosy, and erysipelas, and the diagnosis is readily made, the bullous forms of erythema and dermatitis herpetiformis often present an appearance which renders their differential diagnosis from pemphigus a very difficult task.

The treatment of pemphigus, though frequently unsatisfactory, is capable of producing brilliant results, particularly in children and in adults suffering from a mild type of the disease. Anæmia, chlorosis, hysteria, general debility, and malnutrition are conditions which often underlie the cutaneous disease and require the most careful treatment. Fresh air, nutritious food, and, when possible, a complete change of scene, together with iron, quinine, and strychnia, will in most cases be productive of great benefit.

Arsenic has been most highly recommended by Hutchinson, and in certain cases it seems to act as a specific remedy and to control the recurring outbreaks of bullæ. In many other cases, however, it fails to do much if any good, and should always be used with caution on account of its tendency to aggravate any highly inflammatory eruption.

The local treatment consists in emollient baths and lotions of a soothing and disinfectant character. A severe case of pemphigus requires the constant attendance of a trained nurse, and all dressings of an irritating character or difficult of application should be discarded. The bullæ may be punctured when large and tense, and covered with absorbent cotton until the serum is wholly absorbed. When there are many raw surfaces, soft linen cloths, moistened with oleated lime water or lightly smeared with pure vaseline, may be laid over or bound upon the skin. Shreds of epidermis and the slight crusts resulting from the drying of sero-pus must be gently removed by a disinfectant lotion of the blandest character, and talcum or starch powder used freely about the axillæ and genitals.

## PHTHEIRIASIS

Phtheiriasis, or pediculosis, is a name which not only implies the presence of lice, but applies to the cutaneous lesions which they usually provoke. It is a disease of the poor and miserable, but occasionally it may affect the affluent and cleanly. In patients with an eczematous tendency the disease is often associated with patches of typical eczema evoked by the external irritation.

Phtheiriasis capitis, caused by the head louse, is common in childhood, and not infrequent among women of a lower class. On account of their short hair, men are less likely to suffer. A severe itching of the scalp, with excoriations or eczematous patches, particularly upon the occiput, are invariable indications of the presence of pediculi.

The treatment of phtheiriasis capitis depends upon the severity of the disease, the age, sex, and social station of the patient, and upon the existence of a complicating eczema. When pediculi are few, the ointment of ammoniated mercury rubbed into the hair, especially over the temporal region, where the ova, or "nits," are always most abundant, will usually suffice to destroy these nits and to kill or banish the pediculi. An ointment of carbolic acid (three to five per cent.) may be used in hospital practice, or one of the following combinations:

| | | | |
|---|---|---|---|
| ℞ | Balsami Peruviana | f ʒ i | 10 |
| | Olei olivæ | f ʒ iii | 30 |
| | Petrolei | ad f ℥ i | ad 100 |
| ℿ | | | (Kaposi.) |

| | | |
|---|---|---|
| ℞ | Hydrargyri ammoniati | 6 |
| | Beta-Naphtholis | 6 |
| | Adipis | ad 100 |
| ℿ | | (Dubreuilh.) |

When the head is swarming with pediculi, as is often the case with patients in our public dispensaries, it is advisable to cut the hair, especially in the case of children, and in summer time. The scalp may now be rubbed

morning and night with an ointment of sulphur or carbolic acid with kerosene oil, or with the tincture of staphisagria or cocculus indicus, and shampooed every second day. A corrosive sublimate lotion (1–1000) may be cautiously used when no excoriations or eczematous lesions are present, otherwise it is better to apply equal parts of oil of cade and olive oil. Sulphur or staphisagria in powder form may be rubbed well into the scalp with good effect.

In the case of girls and women with long hair, cutting the infected tresses renders treatment much more convenient, but this is never absolutely necessary, and should generally be avoided. Soaking the hair over night in kerosene by means of an oiled silk cap will kill the pediculi and most of the nits, and repeated applications will effect a cure.

The dead nits or shells of the ova often remain upon the hairs in spite of ordinary treatment. They can best be removed by rubbing each affected hair from root to tip with a soft cloth dipped in alcohol or hot vinegar.

In all cases the head-covering should be carefully examined, and old hats and caps baked in a hot oven or thrown away.

Phtheiriasis corporis, caused by the clothes louse (pediculus vestimentorum), is usually indicated by peculiar lesions upon the body and thighs. These consist of hemorrhagic specks, or so-called "bites," excoriated papules, and numerous parallel scratch marks, especially across the shoulders and over the hips where four finger-nails have been used to tear the skin. In no disease is the pruritis so intense as in pediculosis of the body.

The treatment of phtheiriasis corporis is usually a simple matter, except in cases where the patient is possessed by the idea that the eruption is due to impure blood, and not the direct result of the lice in his clothing. Many ignorant patients actually believe that the eruption breeds the lice, and such cases can only be treated satisfactorily in hospitals where enforced cleanliness is possible.

The two aims of treatment should be to remove the pediculi and to soothe the excoriated skin. A complete and repeated change of clothing is necessary, and while the shirts and drawers are being boiled, the outer gar-

ments should be baked in a hot oven in order to destroy both the pediculi and their ova. This having been accomplished, the irritation of the skin will be greatly lessened, and any pruritus remaining will quickly yield to daily hot baths and the use of a zinc lotion or carbolated vaseline. In dispensary practice, where many patients have a wardrobe too limited to admit of any change and no facilities for bathing, the prescription of sulphur ointment is about all that can be done.

Phtheiriasis pubis, caused by the crab louse, is attended by severe itching of the pubic region, and, in time, by a papular eruption. The lice, being much smaller than those already mentioned, are not readily discovered if unsuspected, but a careful examination usually reveals a number of minute dark specks adhering closely to the roots of the pubic hair.

In the treatment of this disease mercurial ointment has long been a favorite remedy, especially among the laity. While it is extremely efficacious in removing the parasitic cause of the eruption, it is very disagreeable, and often excites an acute eczema of unexpected severity.

The use of the ammoniated mercury ointment, either alone or diluted with an equal part of cold cream, will usually effect a cure without injury to the skin. The following have also been recommended:

℞ Hydrargyri chloridi mitis . . . . . 5
Vaselini . . . . . ad 100
M.

℞ Naphtholis . . . . . 10
Olei olivæ . . . . . ad 100
M.

Covering the pubis for a few moments with a cloth saturated with a small quantity of chloroform (according to Van Harlingen) will kill all living crab lice instantly. The hair may then be washed with hot soap-suds, sponged with vinegar, and combed. The sponging with vinegar may be continued once or twice daily for a week, to get rid of all nits. When patients will permit it, shaving the pubis shortens the cure greatly.

# PITYRIASIS

PITYRIASIS, a name as old as Hippocrates, has long signified a branny desquamation of the skin. With certain adjectives appended, it has been applied to a number of eruptions presenting a variety of clinical appearances. Most of these are identical in origin and nature, while a few of them are distinct diseases to which the name "pityriasis" has become unfortunately attached. For instance, the pityriasis rubra of Hebra is a well-defined and generally recognized disease. Pityriasis rubra pilaris is a name given by French and some other writers to lichen ruber. Pityriasis versicolor, the name used in Germany for chromophytosis, has come into use as the result of an unfortunate attempt to classify skin diseases according to genera and species, and thus to bring all pityriasic eruptions under one head, regardless of their origin and nature.

The pityriasis rosea of Gibert, the pityriasis maculata, circinata, and marginata of Vidal and Duhring, the pityriasis simplex of older writers, and most cases of so-called eczema seborrhoicum, or dermatitis seborrhoica, may be conveniently and justly classed together. They are simply clinical forms of one disease which bears a strong resemblance to eczema on the one hand and to psoriasis on the other, but may be readily differentiated in most cases from either of these diseases.

The clinical forms of pityriasis may be designated by the adjectives maculata, circinata, diffusa, and marginata.

Pityriasis maculata usually occurs as an acute affection and may present a few small scaly discs upon the trunk or extremities, or an eruption which within a few days involves a large portion of the body. The discs are at first erythematous in character and the desquamation which rapidly follows

may be confined to the central portion. The eruption may last a few weeks or several months.

Pityriasis circinata bears the same relation to the form just described that the circinate psoriasis bears to the guttate form. The lesions may be rounded or elliptical in shape, with a pale yellowish centre and a raised border, which may be continuous or punctate in character (lichen circinatus). They generally appear upon the upper portion of the chest, but may be numerous upon the back, loins, and thighs. According to Brocq, a single primitive plaque or circle usually develops a short time before the general or secondary eruption. This, beginning on the neck or breast, gradually extends downwards. Discs and circles are usually found to coexist in this eruption. The disease is always of internal origin, although the annular character of the lesions has led many to regard it as of parasitic origin and some to class it with ringworm (herpes tonsurans maculosus).

Pityriasis diffusa may occur in a mild form upon the face (pityriasis simplex), or it may appear in large patches upon the breast and back, where, owing to the free glandular secretions, the desquamation may have an unctuous character, which has given rise to the names seborrhœa corporis and eczema seborrhoicum. Upon other portions of the body the eruption is quite dry and resembles a superficial eczema. The term seborrhoic eczema, which is applied to it by many writers, following the lead of Unna, is certainly a misnomer, since many of those who use this name admit that the eruption is not a true eczema, and few, if any, will claim that it is at all seborrhoic in character; i.e., due to a flow of sebum.

A diffuse eruption, long known as pityriasis capitis, often occurs upon the scalp. It appears in a variety of forms (known as dandruff), varying from the dry, white flakes which fall readily, to the thick, asbestos-like mass which adheres and mats the hairs together. It is often associated with an erythematous condition of the scalp, and in certain subjects is prone to run into a typical eczema.

Pityriasis marginata is found usually in the folds between the scrotum

and thighs (eczema marginatum), and is sometimes regarded as a ringworm or other parasitic disease of this region. It may also affect the axillæ and the umbilicus, and is commonly regarded as an eczema. The eruption, if untreated, is usually chronic.

The treatment of pityriasis of a mild type consists in some bland inunction calculated to soften the skin, remove the scales, and to lessen whatever itching or irritation may be present. Meanwhile the internal condition causing the eruption should be remedied or allowed to disappear spontaneously, as it usually does in due time. For slight roughness of the skin a little cold cream may be used, or the following lotion applied frequently:

| | | | |
|---|---|---|---|
| ℞ | Sodii boratis . . . . . | ℥ ii | 10 |
| | Glycerini . . . . . | f℥ iss | 5 |
| | Aquæ rosæ . . . . . | ad f℥ iv ad | 100 |

℔

For slight pityriasis capitis frequent shampooing and the use of a two per cent. salicylated oil will usually keep the scalp clean and in time effect a cure. Jackson recommends the application of sweet almond or other oil at night, and in the morning an ointment composed of one drachm of washed sulphur to one ounce of vaseline, the scalp being shampooed every second or third day. When grease is objectionable, as it usually is to ladies with thick hair, the following lotion is a pleasant substitute, the amount of castor oil being increased or diminished according to the dryness of the hair:

| | | | |
|---|---|---|---|
| ℞ | Acidi salicylici . . . . . | ʒ ii | 5 |
| | Olei ricini . . . . . | ʒ iv | 10 |
| | Alcoholis . . . . . | ad ℥ vi ad | 100 |
| | Olei rosæ . . . . . | q. s. | |

℔

The general treatment of dandruff will be found discussed at length under the head of alopecia (page 28).

The treatment of the macular and circinate forms of pityriasis consists in general measures suited to the needs of the patient, and the local use of baths

and emollients. The following ointment will prove of service when the skin is not too irritable:

℞ Hydrargyri ammoniati . . . . . gr. xx 4
Hydrargyri chloridi mitis . . . . . gr. xl 8
Petrolati mollis . . . . . ad ℥ i ad 100
M.

In cases of pityriasis diffusa (dermatitis seborrhoica), sulphur, resorcin, and chrysarobin in ointments of gradually increased strength will prove of service, and some experimentation will often be required to determine just how much stimulation the eruption will bear. In pityriasis marginata, also, the same remark holds true, and the eruption is often aggravated by too strong an application. If marked congestion of the patch is evident, a zinc lotion will prove most agreeable and serviceable, while in other cases the most brilliant result can be obtained from a chrysarobin ointment (two to five per cent.), or the tincture of benzoin, containing one-half per cent. of corrosive sublimate, may be cautiously painted over the patch.

## PITYRIASIS RUBRA

The disease to which Hebra limited the term pityriasis rubra is fortunately as rare as it is fatal. It runs a slow chronic course, and after it has existed for a year or two is characterized by redness and extensive desquamation of the whole body. In time the bright red hue grows duller and the skin becomes atrophied and tensely drawn. The hair falls, the nails become brittle, general emaciation occurs, and the patient succumbs to exhaustion or to some intercurrent disease.

The treatment of pityriasis rubra is intended chiefly to render the patient more comfortable, since in most cases there is but slight hope of a cure. It consists in the frequent use of emollient baths and soothing inunctions.

Internal remedies have little effect. Kaposi mentions one case of recovery

following the internal use of carbolic acid after all local measures had made the cutaneous affection worse. In other cases this remedy, like arsenic, has failed utterly to do good. A decided improvement will sometimes follow the internal use of citrate of potash and the external application of a weak salicylic ointment. In two cases observed some years ago, the disease being in its latter stage, with skin atrophied, inelastic, and tender, no emollient employed seemed to give as great relief to the patients as pure vaseline.

## PSORIASIS

Psoriasis, though not seen as frequently as eczema, is still a very common disease in this as in other countries. On account of its frequency, its characteristic chronicity, and its occasional severity, it constitutes one of the most important of the inflammatory group of skin diseases.

The eruption is always dry and scaly, contrasting in this respect with the moist exuding patches which characterize eczema in its most typical form. Unlike eczema again, the eruption always exhibits a notable tendency to a symmetrical distribution. In both mild and severe cases one side of the body is almost the duplicate of the other. No region is exempt from the eruption, although the scalp, back, and extensor aspect of the extremities are the parts which are usually first and most affected. The palms and soles are usually free, even when the scaly patches are elsewhere abundant, but in rare cases these may also be the seat of the disease.

The lesions of psoriasis present a striking and a varied appearance in different cases, but they are always rounded and sharply defined, never fading off gradually into the surrounding healthy skin, as do the patches of eczema. When at their height of development they are always covered with an accumulation of silvery or yellowish-white epidermic scales, which can be readily scraped off with the finger-nail, leaving the pink corium exposed and a number of bleeding points representing the torn capillary blood-vessels in the cutaneous papillæ.

Various clinical forms of psoriasis have been long since described and

are still recognized as the punctate, guttate, nummular, circinate, gyrate, diffused, and exfoliative varieties. The disease affects both sexes and all ages, having been observed in patients of three months and of eighty-five years. One of the striking peculiarities is a tendency to a recurrence or an exacerbation of a persistent eruption at some certain season of the year. In most cases the eruption undergoes improvement during the summer and increases with the cold weather of the autumn or winter. Occasionally a respite of one or more years will be noted.

The cause of psoriasis is a very interesting study, and yet in the past years, during which the pendulum of scientific opinion has slowly swung from the vague humoral pathology to the modern and more definite germ theory, little, if any, light has been thrown upon the subject. The facts are these: Certain persons in nearly every community show a marked tendency to become psoriatic just as others become rheumatic or tuberculous. The disease often affects several members of a family and appears in successive generations. Those manifesting this psoriatic diathesis or predisposition are usually robust, well nourished, and above the average perhaps as regards physical strength and vigor. The disease runs a remittent or an intermittent course, increasing at certain seasons and partly or wholly disappearing in the meantime. Every psoriatic individual, though often presenting the eruption when in apparently good health, is certain to suffer more intensely when his or her general condition is impaired through dissipation of any sort, insufficiency or excess of food, overwork, anxiety, gestation, lactation, or whatever may exhaust the vitality of either mind or body.

From a careful study of these clinical facts it becomes evident that psoriasis is no more to be considered as simply a scaly eruption on the surface of the skin than rheumatism is to be regarded as merely a local affection of certain joints. It matters little whether we call psoriasis a constitutional disease, like syphilis, of which the eruption is simply an external manifestation, or say that, like urticaria, it is a cutaneous disease of internal origin. It is sufficient to remember that, while local treat-

ment will sometimes remove the eruption, it can never cure the disease—i.e., the almost constant tendency to the outbreak of a characteristic eruption. Hyde rejects the idea that psoriasis is hereditary or that it has any relation to gout, rheumatism, struma, or dyspepsia, and is inclined to regard it as a deformity of the skin (like ichthyosis) rather than a disease.

The parasitic origin of psoriasis, which was claimed at one time, has been given up since the micro-organisms discovered by Lang have been found by Quinquaud in all scaly affections of the skin.

The treatment of psoriasis, like that of nearly all inflammatory affections of the skin, may be conveniently divided into general or hygienic, internal or medicinal, and local measures. The best results can only be obtained by a combination of all three therapeutic agencies. In every case it is well to remember that, however well and strong the patient may appear to be, it is possible, in a slight degree at least, to improve his condition. The very fact that he has psoriasis is sufficient proof that something is wrong, and from my point of view that indefinite "something" which predisposes to the cutaneous eruption is to be found invariably beneath the skin. I have known a professional pugilist to suffer from psoriasis, though at all times a picture of health. Whenever he went into training the eruption invariably disappeared without resort to arsenic or local remedies. I believe firmly that a professional trainer could quickly cure nearly every case of psoriasis who would undergo the strict régime which is enforced upon every aspirant for athletic honors under such control. This being the case, why should not the physician adopt a somewhat similar plan in treating cases in which the customary treatment has failed, and which he is inclined to consider as unusually obstinate, if not incurable? I know that many physicians, in addition to their Latin prescriptions, give excellent advice. They tell the patient to be careful in his diet, to take plenty of exercise, to drink less or to smoke less, and what is the result? The patient takes his Fowler's solution faithfully, but after a day or two eats what he likes and exercises or

smokes when he feels like it. The trainer, on the other hand, not only gives the good advice, but makes it his business to see that it is followed out in every slight particular.

Many patients with psoriasis are clerks, teachers, and others upon whom long hours of exhausting indoor work are obligatory, and for whom much outdoor exercise seems an impossibility. But these are precisely the ones who most need the exercise which is lacking, and by utilizing Sundays, holidays, and early and late half-hours, even they can manage to improve their physical condition to a considerable degree. If a man has no time to eat, starvation is unavoidable. If a patient lacks the opportunity or the inclination to obey the fundamental laws of hygiene, he is bound to suffer, and medical treatment, in spite of a too prevalent medical belief, will rarely suffice to ward off the penalty of disobedience. Many other patients who have time to exercise, and do take a moderate amount of it, have fallen into the pernicious habit of eating far more than they actually require. While many eczematous patients are weak and poorly nourished and need an increased supply of nutritious food, the majority of psoriatics can restrict their diet with great benefit, not only in amount, but in variety. An excessive addiction to meat favors the development of the eruption and keeps the patches in a congested condition, which renders them rebellious to local applications which might otherwise do much good.

A poor circulation often makes psoriasis more difficult to cure, and a cool tub bath every morning, in addition to vigorous exercise, will tend to overcome this condition. In all cases, and especially in inveterate ones, resort to the Turkish bath is beneficial. Unfortunately, the public baths extend no welcome to patients with an extensive eruption, and the private box bath, involving, as it does, an extra room and more or less expense, cannot well be prescribed in a large number of cases.

Among the many internal remedies which have been employed in the treatment of psoriasis, arsenic is usually placed at the head of the list. In no other skin disease is it capable of producing such a brilliant therapeutic effect. And yet, when administered in every case regardless of the

condition of the skin it usually does harm in ten cases where it benefits one.

Arsenic is contraindicated in psoriasis when the eruption is increasing or when the patches are in an irritable or highly congested state. On the other hand, when the disease is tending to improve spontaneously, or in any chronic case in which the patches do not present a reddened and angry appearance after the scales are removed, arsenic may be prescribed with great benefit. Small doses should be given at the outset, and increased steadily until the eruption yields, unless a toxic effect is produced which calls for a diminution of the dose or a complete cessation of the remedy. When the eruption is extremely obstinate and no unpleasant effects are produced, the administration of the drug may be continued for many months. Indeed, when a notably beneficial effect is obtained in psoriasis, it is advisable to continue the arsenic even after the last trace of the eruption has disappeared. But when impairment of digestion results from its use, as frequently happens, the continuance of the drug is liable to injure the stomach far more than it can possibly benefit the skin.

Arsenic is most frequently given in the form of Fowler's solution (Liquor potassii arsenitis, U. S. P.), well diluted, after each meal. The dose may be gradually increased from five to thirty drops if the patient is found able to tolerate the larger amount without unpleasant symptoms, such as puffiness of the eyelids, a burning sensation in the stomach, looseness of the bowels, or pigmentation of the skin. Some patients may be able to take even larger doses, but permanent harm has often resulted from "pushing" the remedy in accordance with the advice of former writers.

The solution of arsenous acid (Liquor acidi arsenosi, U. S. P.), as well as the solution of sodium arsenate (Liquor sodii arsenatis, U. S. P.), are of the same strength as the solution of potassium arsenite (1–100). Tablet triturates of arsenous acid containing from one-fiftieth to one-tenth of a grain may be found more convenient for patients to take, and, in my experience, are no more apt to disturb the digestion.

In cases where the psoriatic eruption is irritable and liable to be aggravated by the use of arsenic, the alkaline diuretics will invariably prove of the greatest service. Potassium citrate or acetate, given in a dose of twenty grains or more in a glass of water before each meal, will increase the renal secretion and speedily lessen the congestion of the patches. In all plethoric patients, and especially in those with a rheumatic or gouty tendency, this remedy is one of the most reliable at our command. If it does not alone effect a cure of the psoriasis, it will put the patient in a condition which will greatly enhance the value of any subsequent arsenical treatment. Potassium iodide in large doses has been found by Haslund and others to be an efficient remedy in psoriasis, but my experience has led me to the belief that it acts simply as an alkaline diuretic and has no advantage over the citrate or the acetate.

In acute forms of psoriasis, and in cases in which the subjective symptoms are very pronounced, Malcolm Morris has found antimony to be very useful. He gives from five to ten minims of the wine of antimony three times a day. Carbolic acid has been advocated by Kaposi for internal use, and an action analogous to that of arsenic has been claimed for it. Ten or fifteen drops of the acid may be administered daily in the form of pills made with the extract of liquorice as an excipient. Crocker speaks highly of turpentine, stating that under its use the hyperæmia of the skin is reduced, the scales fall off, and many cases get quite well in about two or three months. It may be given in the form of an emulsion, the oil of turpentine being rubbed up with mucilage of acacia. The dose may be gradually increased from ten to thirty minims after each meal. Barley water should be taken freely during the treatment, to avert the possibility of unpleasant urinary complications. Cantharides, copaiba, and gurjun oil have also been praised for their efficacy in the cure of psoriasis, but all remedies which may produce only a slight improvement in a psoriatic eruption at the risk of possible injury to the urinary organs may well be discarded. Mention might be made of many other internal remedies which at various times have been highly recommended, but it will suffice to say that none of them can compare in value with the alkalies and arsenic.

The good repute which some remedies have attained is doubtless due to the fact that psoriasis, as has been remarked, is so frequently intermittent in its course. It increases and decreases at certain seasons and with varying conditions of the patient. When a chronic case of psoriasis is taken from a dispensary clinic and put in hospital, the regularity of the diet, the enforced rest, and the continuous warmth of the bed will usually benefit the patient in a marked degree, and the eruption will tend to improve and sometimes to disappear in a few weeks. If thyroid extract, clover tops, or some other useless remedy is administered during this period, an enthusiastic paper is very apt to be published on the remarkable effect of the remedy in the cure of psoriasis.

In the local treatment of the eruption many remedies have been recommended and used, and a score or more of them are usually mentioned in every text-book. But there is one local remedy the therapeutic action of which so far surpasses that of every other known remedy that, if it is desired to remove psoriatic patches from the skin in the shortest possible time, no other application should be thought of. That remedy is chrysarobin. Its capabilities in the cure of psoriasis, or at least in the removal of psoriatic patches, is simply marvellous. Such a remark is not infrequently made by some enthusiastic writer commenting upon a new drug or preparation which he has tried but a few times, but it is rarely made concerning a remedy which one has been constantly using for a quarter of a century. The brilliant therapeutic effect of chrysarobin cannot be obtained, however, by one who has had little or no experience in its use and who is ignorant of how and when to use it. Frequently it does harm. It often inflames the skin of a patient until he looks like a boiled lobster, and suffers perhaps even greater agony. It invariably stains, and usually ruins the patient's underwear and his bed-linen. And not infrequently, when the patient receives no caution as to his danger, it is inadvertently rubbed in or about the eye, and sets up an intense conjunctivitis which is usually far more disagreeable, if not more serious, than the eruption for which it has been prescribed. But the great point in its favor is that it always produces an

effect. If it fails to do good, it is certain to do harm. Unlike the many vaunted remedies which we have carefully used and finally failed to discover whether they were of slight value or perfectly inert, the remedy in question is one which never can be accused of producing a doubtful result.

In cases of psoriasis in which the skin is irritable and the congested patches are tending to increase in number and extent, chrysarobin, like arsenic, is contraindicated, and likely to increase the eruption if applied. But when the eruption is tending to disappear, or when chronic, thickened patches have remained unchanged in appearance for a long time, an ointment of varying strength, suited to the requirements of the case, will speedily remove the scales and lessen the infiltration. A curious effect is usually produced. The healthy skin surrounding the patches becomes reddened, partly from inflammation and partly from the staining effect of the drug. Around the scaly discs or patches a whitish line is commonly produced, and gradually the psoriatic eruption, instead of appearing as red, scaly spots on a background of light normal skin, is converted into smooth white discs or patches upon a background of a dull indian-red hue. The ointment may now be discontinued, and the reddened or stained skin will gradually return to its normal appearance. When a considerable degree of inflammation has been occasioned, more or less desquamation is apt to occur, as after an attack of scarlatina.

The best effect of chrysarobin can always be obtained by the use of an ointment. This should be thoroughly rubbed into the scaly patches by means of a swab or tooth-brush, as it stains the nails badly when the patient uses his fingers for this purpose. Old or discarded underwear may be advantageously worn night and day during this treatment by inunction, and only such bed-linen used as can be cheerfully sacrificed in behalf of the cure. No amount of washing will remove the purplish-red stain occasioned by the use of this drug.

The Unguentum Chrysarobini of the United States Pharmacopœia is of ten per cent. strength, and well suited to the majority of cases. It is often advisable, however, to commence with an ointment of from three to five

per cent. in strength, watching its effect, and increasing the percentage if it seems advisable to do so. In chronic, thickened patches, especially upon the legs, it is often necessary to use a twenty per cent. ointment.

In order to use chrysarobin, and at the same time to lessen its disagreeable effects, many devices have been suggested, such as incorporating the powder in plasters and varnishes. These are less likely to produce extensive dermatitis and staining of the clothing, but they are inferior to an ointment in quickly removing the psoriatic patches. One of the best of these is a solution of gutta-percha containing five or ten per cent. of chrysarobin. A combination of salicylic acid with chrysarobin in collodion I have used for many years, and found it extremely serviceable. The following is the formula:

℞ Chrysarobini . . . . . 10
Acidi salicylici . . . . . 10
Etheris . . . . . 15
Collodii flexilis . . . . . ad 100
M.

This may be painted over the patches every day or two until the scaling has disappeared and smooth white spots are left.

It is inadvisable to use chrysarobin upon the scalp or face, as it discolors the hair and is very liable to get accidentally rubbed into the eyes, and thus cause conjunctivitis. In psoriatic patches upon the head the ointment of ammoniated mercury may be conveniently used in its stead. Although this ointment has little effect upon psoriasis of the body, it will often suffice to remove the eruption from the face and scalp.

Before the introduction of chrysarobin, tar was the chief remedy in the treatment of psoriasis, and the oil of cade is still an efficient, though disagreeable remedy. Upon the scalp it may be applied diluted with alcohol or almond oil. On the body it may be used mixed with five parts of glycerole of starch. Pyrogallic acid, aristol, and various other remedies have been highly recommended and extensively used by many in the cure of psoriasis. None of these remedies can compare in efficacy with chrysarobin, and some of them possess qualities which are quite as objectionable.

Baths of various kinds and soap frictions are commonly advised for the purpose of removing the psoriatic scales, but usually they occasion more trouble than benefit. When the skin is highly inflamed or extremely itchy, prolonged hot baths, followed by the inunction of vaseline or almond oil, will often give relief. But when the skin is in a condition which will permit the use of a mild chrysarobin ointment, this will be found to remove the scales far more quickly than any amount of soap and water.

In some cases of chronic psoriasis, where the various local remedies mentioned appear to have no beneficial effect, an excellent plan is to have the patient wear a suit of closely fitting underwear made of vulcanized rubber sheeting. The rubber surface next to the skin softens and removes the scales, lessens the redness and thickening of the patches, and may effect a cure in some cases which have proved intractable to the ordinary methods of treatment.

To sum up the treatment of psoriasis in a few words, it may be said that at the outset in most cases, while the general health of the patient is being improved by a judicious system of exercise and diet, the best remedies are alkaline diuretics internally and vaseline locally. When the patient is in his or her best physical condition, and the irritability of the skin has been lessened by the treatment mentioned, then arsenic can be given internally and chrysarobin applied locally, with an excellent prospect of effecting a speedy cure. By a cure is meant a restoration of the skin to its normal condition. The tendency to psoriatic outbreaks, like the tendency to gout or rheumatism, is not a mere local affection of the skin or of the joints. In either case it is constitutional, and occasionally seems to be ineradicable. Psoriasis may be cured, i.e., the eruption may be forced to disappear, but, as experience teaches, it may be confidently expected to return as soon as the patient resumes his former mode of life.

# PLATE XLIX.

SEBORRHOEA STEATOMA

MILIUM

## SEBORRHŒA—STEATOMA—MILIUM

The term seborrhœa sicca has been applied to a variety of affections in which there is neither increase nor modification of the sebaceous secretion and to which the name pityriasis would be far more applicable. Seborrhœa oleosa implies an abnormally oily or greasy skin. It commonly affects the face or scalp. Upon the nose and adjoining region is sometimes seen a circumscribed patch of congested skin dotted with numerous follicular openings. Occasionally, as in the case of the patient in the plate a greasy pellicle forms upon the surface of the patch.

Steatoma (wen or sebaceous cyst) is a rounded tumor containing sebaceous matter. It commonly develops upon the scalp or forehead in adult life. The growth is of variable size and is supposed to originate in a distended sebaceous gland, the duct of which has become obliterated. In time the resulting tumor is composed of a dense capsule containing whitish matter. Occasionally, as in the case of the patient in the middle illustration, the sebaceous duct remains and pressure may cause the contents of the cyst to be extruded in the form of a cheesy thread.

A milium is a distended sebaceous gland—a steatoma on a small scale. It is usually seen upon the upper portion of the face, especially on the eyelids and malar region, and appears as a dense yellowish-white miliary mass imbedded in the skin just below the epidermis. As a rule, a milium has no duct. Occasionally, as in the case of the patient in the plate, the cheek may be dotted with minute white milia or distended sebaceous glands, from which the contents can be pressed out (acne albida of older writers).

SEBORRHŒA. STEATOMA. MILIUM

PLATE L.

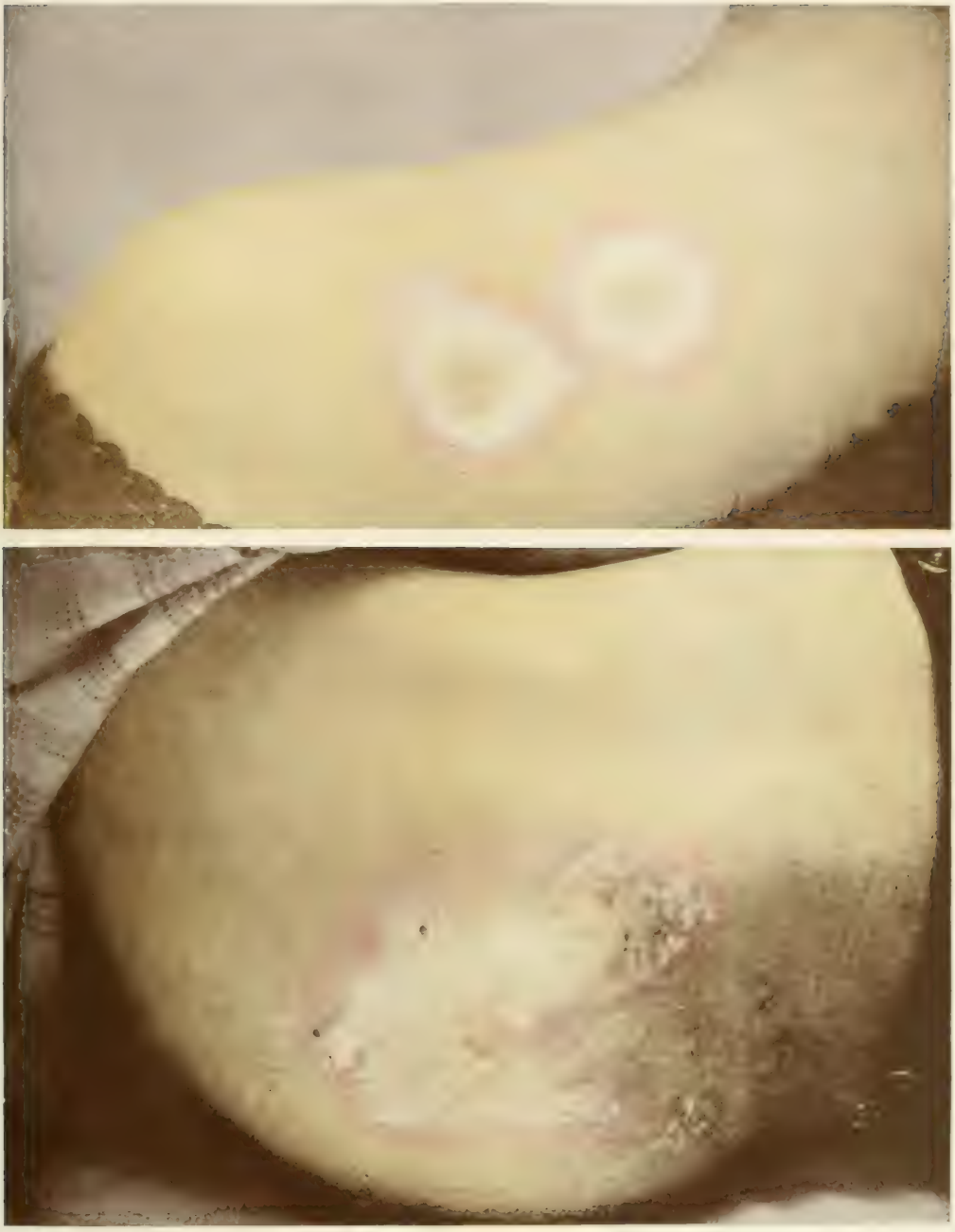
MORPHOEA

# MORPHŒA

Morphœa begins by the development of small spots which at first are smooth and of a dull whitish hue. These become wrinkled and of a horny character as they increase in size. The patches are usually surrounded by a faint zone of a peculiar violaceous tint. They develop slowly, persist indefinitely, and sometimes disappear spontaneously.

In the upper illustration is seen a rare form of morphœa occurring in circles upon a woman's shoulder. The disease was of several years' duration, having begun on the right forearm. Minute whitish spots soon were found on both arms. Many of these coalesced, forming irregular or oval patches. The rings upon the shoulder appeared as though sunken or inserted into the skin and were surrounded by a faint lilac hued halo.

In the lower illustration a more common and typical form of the disease is shown upon the right hip of a man aged thirty-six. The patch was of eighteen months' duration, having begun in the form of several small whitish spots, which multiplied and coalesced as they increased in size. This composite patch was irregular in form and presented the dense fibrous condition of the skin with the shrivelled surface which is usually characteristic of a well developed case. Upon the patient's right calf the disease had existed for two years. The skin in this region was slightly hidebound, as in cases of scleroderma, and presented an atrophied or cicatricial appearance. The galvanic current was used with beneficial effect in this case.



MORPHŒA.

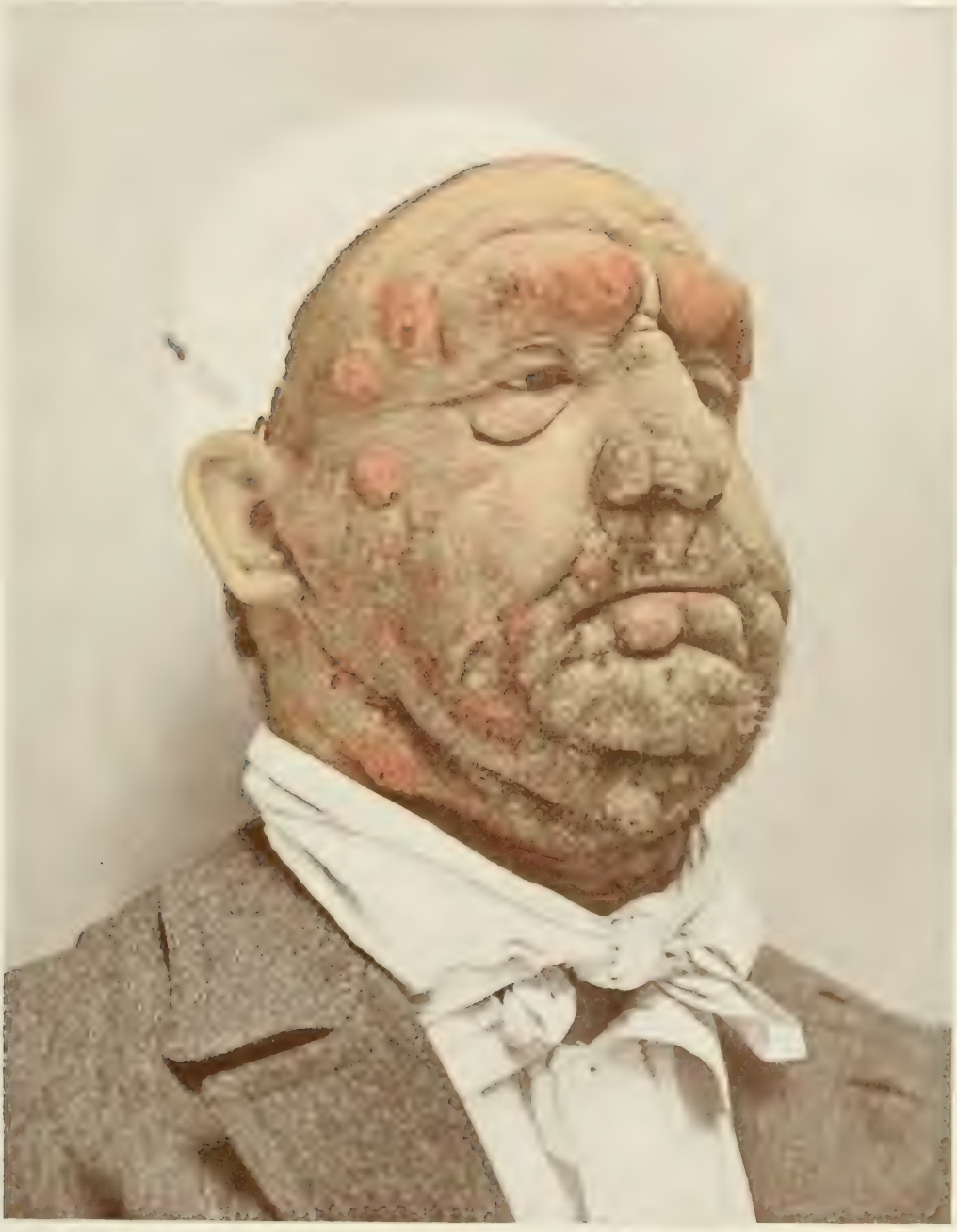
PLATE LI.

MYCOSIS FUNGOIDES

## MYCOSIS FUNGOIDES

The patient whose face is portrayed in the accompanying plate was at the New York Skin and Cancer Hospital, where he suffered for over a year from a general, and for the most part, a typical eczema. The early stage of mycosis fungoides is often characterized by an eruption which looks very much like a dry eczema, but this patient presented large areas of a moist eruption which was attended by intolerable itching. The only peculiarity of this eczema was its unusual obstinacy. It seemed impossible to obtain relief, not to speak of a cure, through methods of treatment from which much benefit would be ordinarily expected. Finally a number of tumors appeared upon the face and trunk and the serious nature of the disease became apparent.

Before and after leaving the hospital the disease grew steadily worse, and after his death in a neighboring city, I learned that a diagnosis of leprosy had been made and based upon the finding of leprous bacilli. It is possible that this patient might have become infected with leprosy, but all the symptoms were plainly those of mycosis fungoides. It is also possible that the microscopical examination of the tissues may have been at fault. The size and softness of the tumors in this case and the rapidity of their growth and disappearance are by no means characteristic of leprosy, and a comparison of this plate with the one preceding will doubtless enable any one familiar with the two diseases to make a correct diagnosis in each case from the portrait.



MYCOSIS FUNGOIDES.

# PLATE LII.

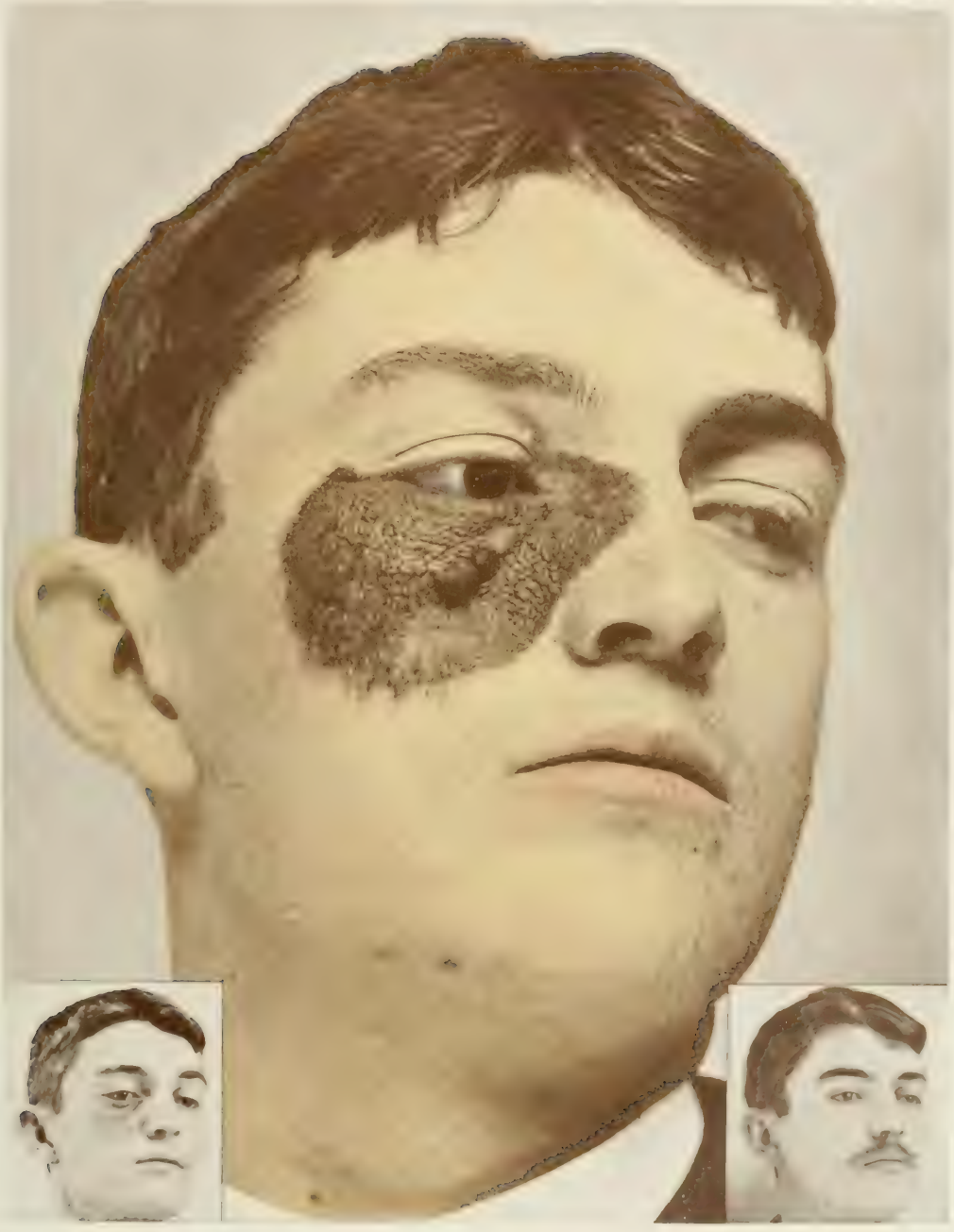
NÆVUS PILOSUS

## NÆVUS PILOSUS.

Nævi or "moles" of a yellowish or brown color and smooth surface often appear upon the skin in youth or adult life, and seem like permanent freckles. These pigmentary nævi are sometimes raised above the surface of the skin and often present a rough or warty surface. In most cases they are covered by a growth of fine or coarse hair, and constitute the hairy mole or nævus pilosus. They are congenital, most frequently found upon the face and back and often cover a large extent of surface.

The patient represented by the plate had a raised warty growth upon the right cheek, involving the lower eyelid and extending up to the ridge of the nose. It was of a very dark hue and covered by a growth of coarse hair which the patient frequently trimmed with the scissors. In the center of the patch was a dry, blackish friable tumor resembling a cutaneous horn.

The treatment of this case by means of the electrolytic needle was slow and tedious but productive of a most satisfactory result. The growth was entirely removed, leaving a smooth and scarcely perceptible scar with not the slightest deformity of the eyelid. The small portrait at the lower left hand corner of the plate shows the appearance of the face at the close of the treatment, while the other portrait shows a still further improvement, which was simply the result of time.



NÆVUS PILOSUS.

PLATE LIII.

NÆVUS VASCULARIS

# NÆVUS VASCULARIS

Nævus vascularis results from a permanent dilatation of the blood vessels of the skin and presents four clinical forms:

1. Nævus araneus is a small red spot which usually appears upon the face in early life. It presents radiating vessels which suggest the legs of a spider.

2. Nævus flammeus or "port wine mark" is a congenital affection commonly located on one side of the face or body. It varies in size from a very small patch to one affecting half the face or a large portion of the trunk. The color is sometimes rosy, but generally dull red or purplish.

3. Nævus tuberosus may occur as a vascular excrescence often seen upon the surface of a port wine mark, as a small rounded tumor, or as a raised lumpy birthmark of irregular shape. It varies from a bright red to a dull bluish tint, according to the arterial or venous character of the tumor.

4. Nævus cavernosus is a sub-cutaneous tumor, in which is a mass of dilated veins or arteries surrounded by firm connective tissue. The overlying skin is often normal in hue.

The plate shows an extensive wine mark upon the right arm and lower scapular region with a few outlying patches of the same nature. Here and there are the small vascular excrescences which frequently develop upon the surface of a large nævus. Upon the arm near the axilla is seen a patch of ulceration and crusting, a condition which is very unusual in vascular nævus.



NÆVUS VASCULARIS.

# PLATE LIV.

## PAPILLOMA LINEARE

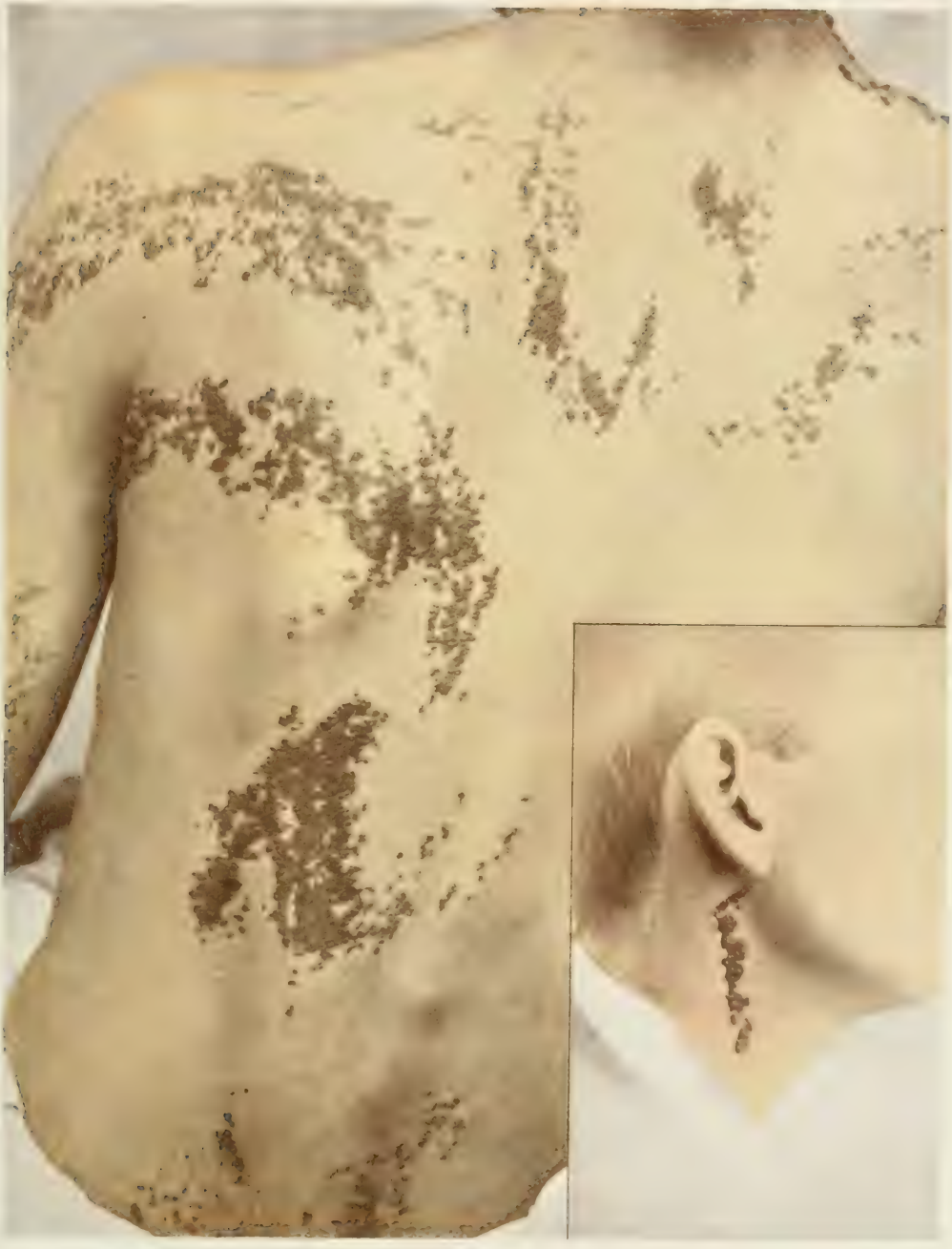
## PAPILLOMA LINEARE

Papilloma lineare (or nævus verrucosus linearis) is a pigmented and warty growth, either congenital or acquired, which develops in lines or elongated patches, usually upon one side of the body.

The patient whose back is partly shown in the accompanying plate was a girl of fifteen, in fair health though thin and nervous. She stated that her skin had been smooth at birth and that the warty patches had first appeared when about six months old. Since puberty they had increased in extent and become much darker. Her skin was smooth and normal except where patches of dark warty excrescences appeared. These were chiefly upon the left side of the breast and back and upon the anterior surface of the left thigh. These groups of papillomatous lesions were irregular in form but showed a marked tendency to a linear distribution, especially upon the extremities. They were raised considerably above the surface of the skin and of a deep brown or blackish hue.

The few patches upon the right side of the trunk were removed by the curette with considerable difficulty, owing to their firm consistence, and left a notable contrast in the condition of the two sides.

The patient represented in the lower corner of the plate was a young man who presented a vertical line of dark, slightly pedunculated, fibrous excrescences running down the right side of the neck. His skin was elsewhere quite normal. Owing to the dense character of this warty growth, an attempt to remove it by means of the curette proved a failure and it was found necessary to excise it with a pair of sharp curved scissors.



PAPILLOMA LINEARE.

PLATE LV.

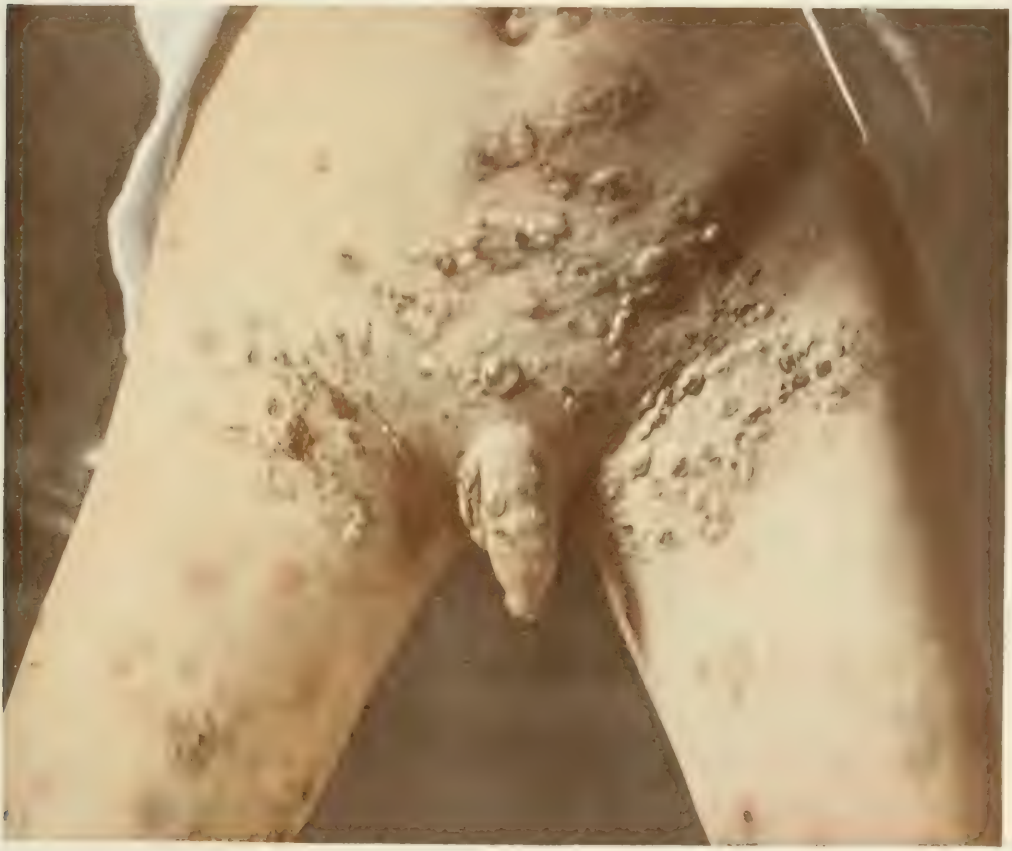
PEMPHIGUS

# PEMPHIGUS

The patient represented in the upper illustration was a boy of fourteen, delicate and undersized. From five to seven years of age he suffered from a general bullous eruption. The present attack had lasted three months. The eruption was symmetrical and appeared on the forearms, backs of hands, legs and feet, and to a slight degree upon the face and neck. In the two months during which he was under my observation there was a constant recurrence of bullæ and severe itching of the skin where the lesions had dried and crusted. The eruption seemed to be checked but was not cured by the use of arsenic, a remedy which is often of great value, though by no means a specific, in this disease.

Upon the arm the tense rounded bullæ springing from an apparently sound skin are plainly seen, as well as the various stages of drying and crusting through which the lesions pass and the serpiginous form which often characterizes the eruption especially in children.

The subject of the lower illustration was a little boy in the Clinic of the Skin and Cancer Hospital who had suffered from several acute attacks. Here again are seen the tense bullæ with dried and crusted lesions, and also the dull red stains of recent lesions and leucodermatous spots upon the abdomen where the eruption had previously existed. In this case the use of arsenic combined with general tonic treatment was speedily followed by a complete disappearance of the eruption.



PEMPHIGUS.

# PLATE LVI.

PHTHEIRIASIS CORPORIS

## PHTHEIRIASIS CORPORIS

The eruption resulting from the presence of lice in the clothing is almost wholly due to the action of the finger nails and consists of numerous excoriations with scratch marks which are usually long and often parallel. Here and there a close scrutiny may detect the hemorrhagic points where the pediculus has inserted its haustellum in order to enjoy its sanguineous feast, but the diagnosis is commonly based upon the character and location of the scratch marks. These are generally most numerous across the shoulders, around the waist, and upon the outer surface of the thighs. In the case of patients who have suffered for many weeks or months from the presence of lice in the clothing, the eruption may cover the trunk and extremities and be associated with a marked pigmentation of the skin.

Upon the back of the patient shown in the illustration the abundant excoriations indicate that the pediculi were numerous and had infested the clothing for a long time. As is usually the case, the shoulders and the lumbar region had suffered most.

A bath, a complete change of clothing (or a thorough baking of the infested garments in a hot oven), and a ten per cent. lotion of carbolic acid will speedily relieve the itching through removal of the cause, and effect a cure of the disease.

PHTHEIRIASIS CORPORIS.

PLATE LVII.

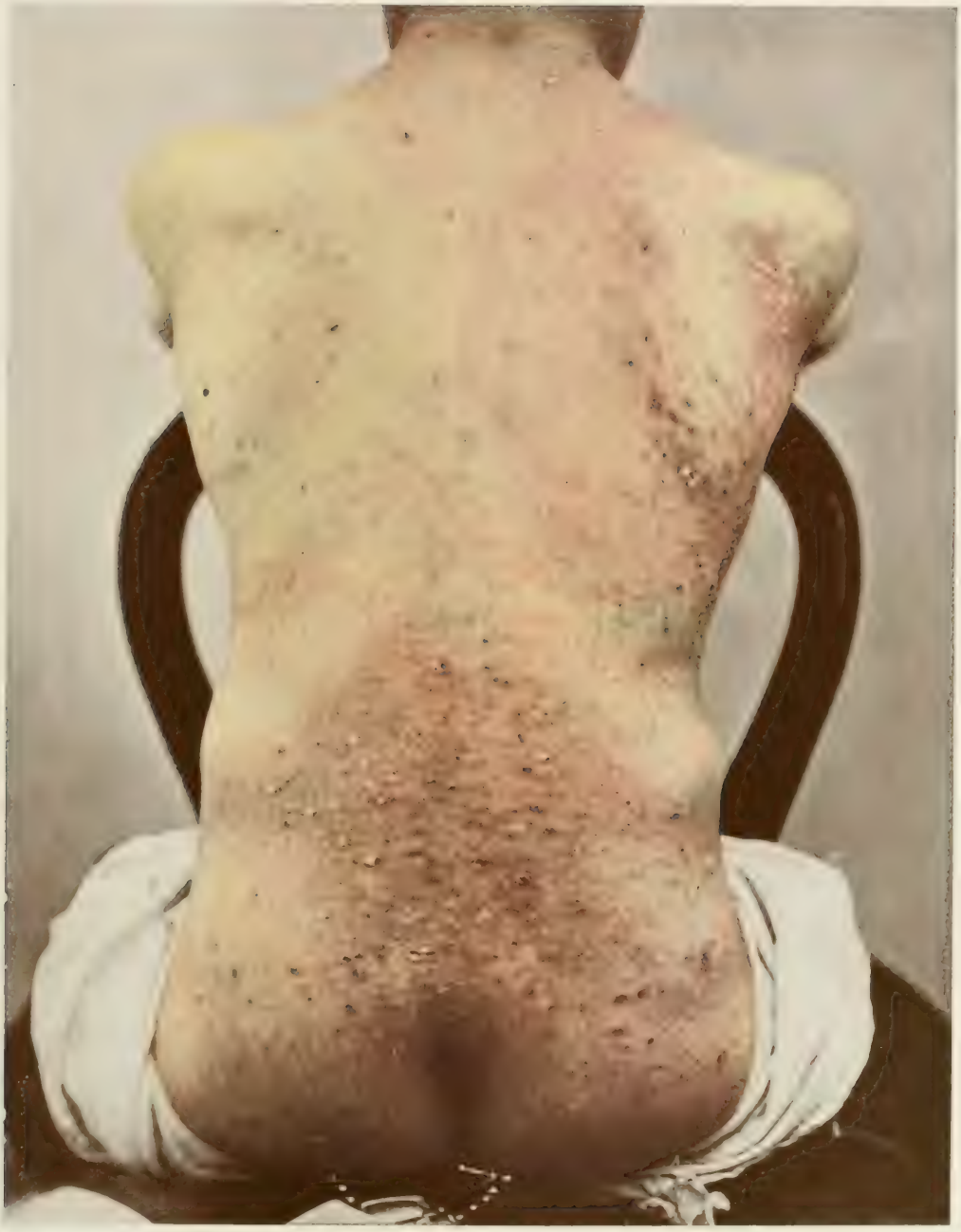
PITYRIASIS MACULATA

## PITYRIASIS MACULATA

Pityriasis is a superficial inflammatory affection of the skin, occurring either in small rounded discs, in rings, or in diffused patches, and is characterized by a light roseate hue and a branny desquamation. It is often classed with eczema, but differs from this affection in several important features. It usually runs a self-limited course, and never presents any notable thickening of the skin nor manifests any tendency to moisture. It differs from psoriasis in beginning as an erythema, in presenting only a slight degree of scaling, in usually running an acute course, and in showing no tendency to recurrence at certain seasons.

In the case of the patient who was the subject of the accompanying illustration, the eruption appeared suddenly over the trunk and in less degree upon the extremities, and for a few days bore a slight resemblance to an erythematous syphilide. Many of the discs or roseate macules soon began to desquamate, and in a few weeks the eruption disappeared without any vigorous treatment.

The general resemblance of the eruption to a guttate psoriasis, as well as the characteristic points of difference, may be readily seen by a comparative examination of the plates illustrating these two affections. While all of the guttate lesions of the psoriatic patient were covered with thick silvery scales, most of the lesions in the case of pityriasis were simply erythematous at the outset and the desquamation was slight and secondary.



PITYRIASIS MACULATA.

PLATE LVIII.

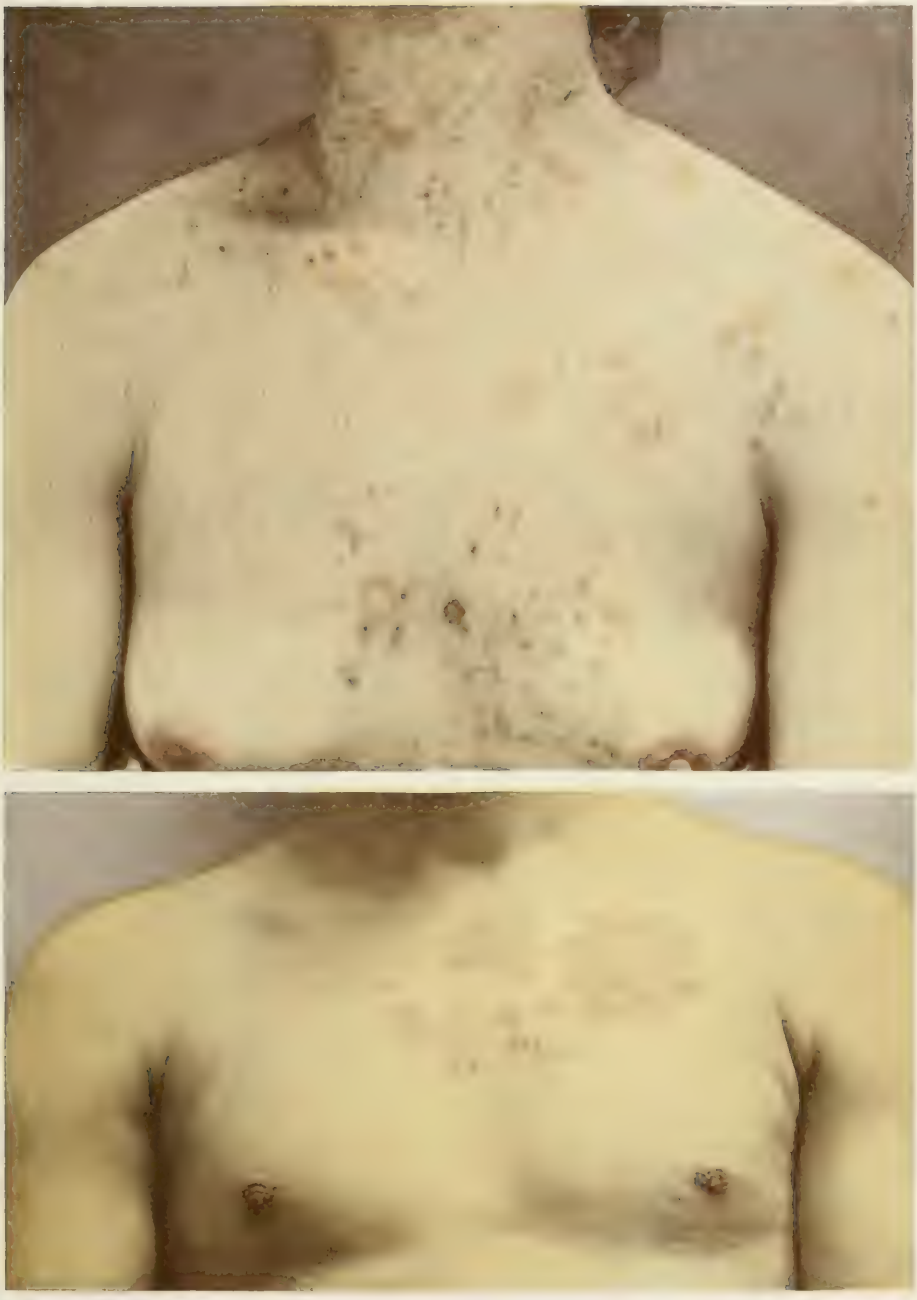
PITYRIASIS CIRCINATA

# PITYRIASIS CIRCINATA

To the circinate form of pityriasis a variety of names have been applied. When it occurs upon the anterior portion of the chest, which is a favorite location, it is often designated as pityriasis rosea, lichen circinatus, or seborrhœa corporis. Upon the extremities or other portions of the trunk it is frequently called eczema seborrhoicum, despite the fact that it is not an eczema and has no relation whatever to the sebaceous glands. In patients with a marked eczematous tendency, however, a part of the eruption may become irritated and a secondary eczema develop, as it often does upon a patch of trichophytosis. Although the eruption is undoubtedly of internal origin, many believe in its parasitic nature, and some have regarded it as disseminated ringworm (herpes tonsurans maculosus).

In the case of the female shown in the upper illustration the eruption, as is frequently the case, occurred in both the macular and circinate form. Many of the patches, as they increased in size, assumed a circular or oval outline and presented a central area of a dull, yellowish hue surrounded by a scaly margin. The disease ran an acute course.

In the lower illustration the eruption upon a male chest is seen to be more confluent and to present a slightly papular character. When such an eruption occurs over the sternum it may run an acute course of one or two months, but in many instances it shows a tendency to relapse and to become chronic.



PITYRIASIS CIRCINATA.

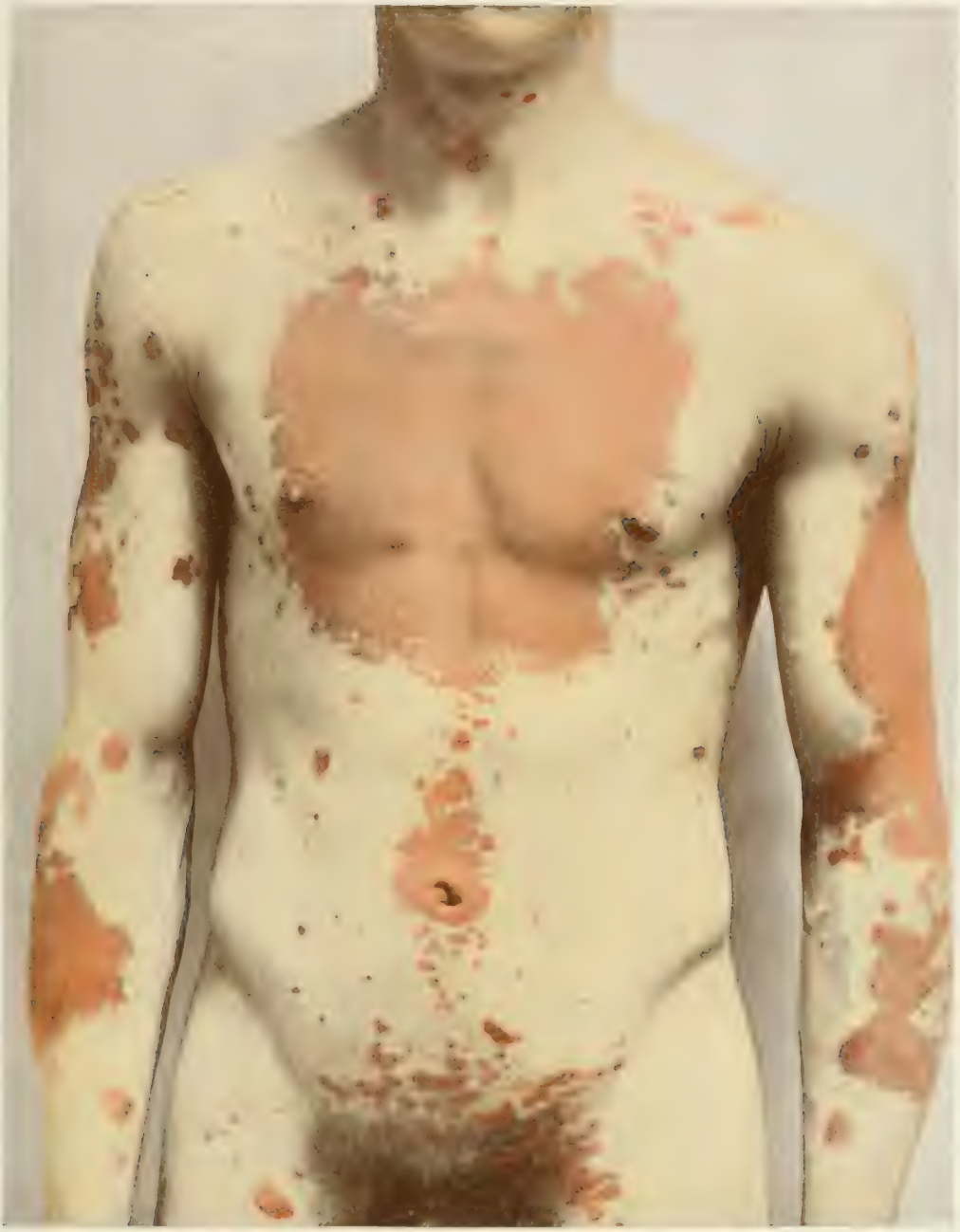
# PLATE LIX.

## PITYRIASIS DIFFUSA

# PITYRIASIS DIFFUSA

In the case of the patient who was the subject of the accompanying illustration the eruption was of four months' duration, having begun in the form of numerous small, scaly, punctate and guttate patches. These coalesced and formed diffused marginate patches of a purplish red hue and with a very slight amount of mealy desquamation. The eruption was found upon the scalp, face, arms, axillæ and pubis, and especially upon the sternal and spinal regions. There had been considerable scaling and itching at the outset, but there was little at the time the photograph was taken.

The diagnosis in this case was perplexing. The peculiar purplish hue was a notable feature and was strongly suggestive of lichen planus, but there were no angular, flattened lesions typical of this disease. The eruption presented certain features suggestive of both eczema and psoriasis, but there was no tendency to exudation, no evidence of scratching, nor any formation of silvery scales. A diagnosis of eczema seborrhoicum, eczema marginatum or seborrhœa pityriasiformis might have been made, but after a careful study of the case it seemed evident that the smaller lesions were essentially the same as those found in cases of pityriasis maculata *seu* rosea, and hence the diagnosis of pityriasis was made and a descriptive adjective appended which would suggest the occurrence of large, smooth patches, instead of the branny discs and rings which are more commonly observed in this disease.



PITYRIASIS DIFFUSA.

# PLATE LX.

PITYRIASIS SEBORRHOICA

# PITYRIASIS SEBORRHOICA

The disease portrayed in the accompanying plate is one to which has been applied a bewildering variety of names. It is most frequently found upon the scalp in varying degrees of severity, and in its mildest form is commonly recognized as "dandruff." The dermatologists have called it pityriasis, seborrhœa, erythema squamosum, eczema squamosum, eczema marginatum, eczema seborrhoicum, dermatitis seborrhoica, etc., etc., and differ widely in their descriptions and views as to its precise nature. It is essentially a branny desquamation of the skin, associated with slight superficial inflammation, running an acute, subacute or chronic course, and presenting rounded discs, rings or diffused patches with either a marginate or an indistinct border. From a clinical aspect it should be differentiated from both eczema and psoriasis, to either of which it may bear a strong resemblance.

Although pityriasis is always a dry eruption, it may become the seat of a secondary eczema, especially upon the legs and when occurring in patients with a disposition to the latter disease. Upon the scalp and also about the nasal, sternal and interscapular regions, where the skin is naturally oily, the desquamation is frequently of a greasy character. From this fact originated the erroneous idea that the eruption resulted from a perverted function of the sebaceous glands. The affection may be accompanied by moderate pruritus and usually yields to the application of mildly stimulating ointments.

PITYRIASIS SEBORRHOICA.

## PLATE LXI.

PSORIASIS PUNCTATA PSORIASIS CIRCINATA

PSORIASIS NUMMULATA PSORIASIS DIFFUSA

# PSORIASIS

The clinical forms of psoriasis differ so greatly in appearance that, at first glance, they might be regarded as distinct affections of the skin, but a little study of their characteristics will reveal their identity. The eruption invariably preserves its peculiar dry and scaly type, and the disease is always intermittent and usually chronic in its course. One clinical form often changes into another, the guttate becoming nummular or circinate, and any neglected case in time becoming diffuse and inveterate.

The first illustration shows the punctate form of the disease, which is comparatively rare and usually seen in children.

The second illustration shows the tendency of psoriatic patches to heal in the centre (like ringworm and the serpiginous syphilide) and to leave an elevated border composed of the more recent lesions. If the photograph of this patient had been taken a few weeks earlier, small and perfect circles would have been seen. These have enlarged and coalesced into figure of eight or other irregular patches, and the margin has broken up into isolated scaly papules.

The third illustration presents a nummular or coin-like eruption on the back, the discs tending to heal in the centre and become circinate as well as to coalesce and become diffuse.

The fourth illustration shows the diffuse or inveterate form of the disease. These large patches, by spreading at the periphery and coalescing, sometimes produce fantastic outlines on the body. The patient photographed was in poor health, and though the eruption yielded to treatment, a speedy relapse seemed inevitable. She suffered also from psoriasis of the nails in a marked degree.

PUNCTATA.
NUMMULATA.

# PSORIASIS.

CIRCINATA.
DIFFUSA.

PLATE LXII.

PSORIASIS GUTTATA

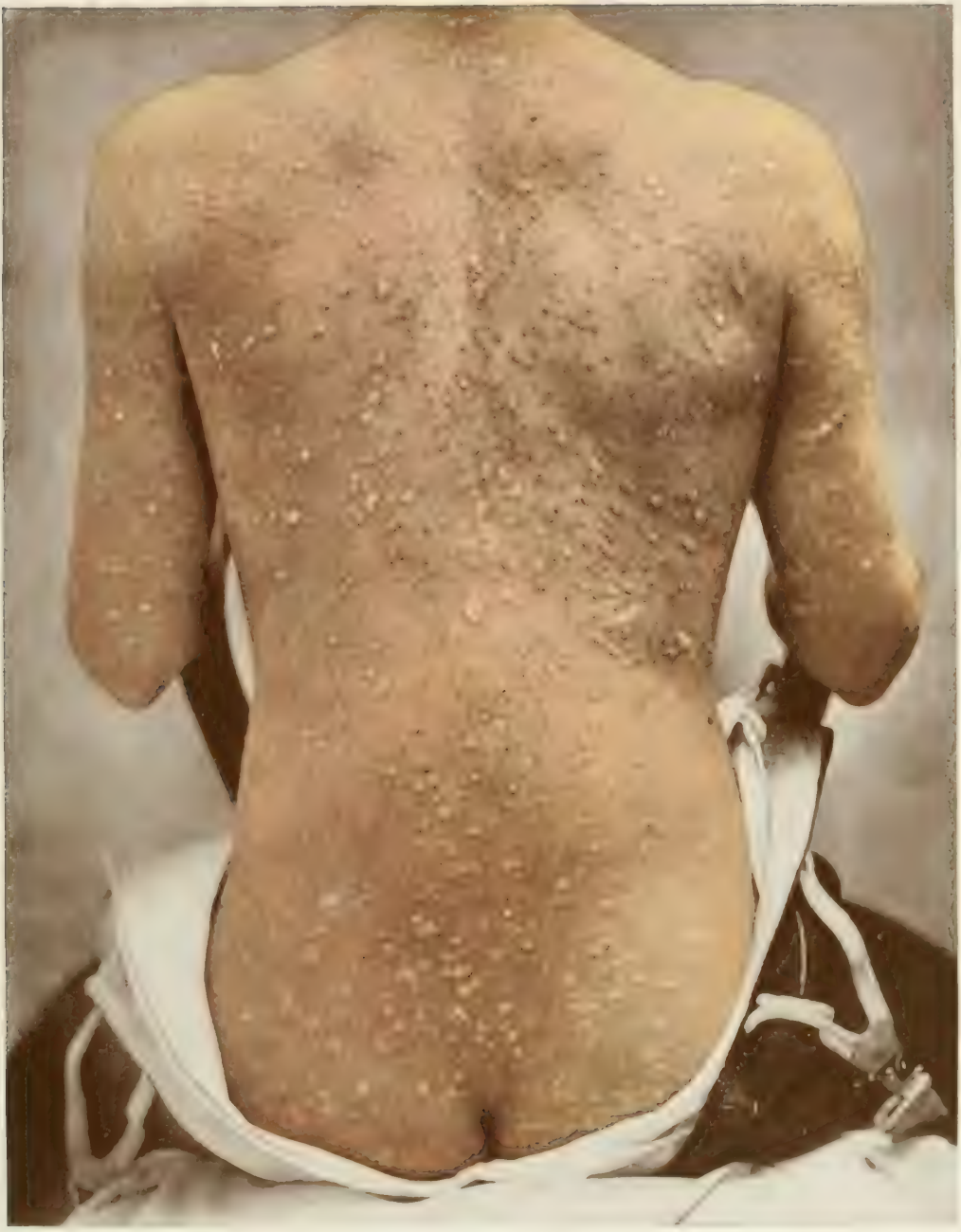
## PSORIASIS GUTTATA

This illustration shows a mild type of the disease, although there was an unusually large number of small, dry, scaly papules covering the trunk and limbs. The silvery scales could be readily scratched off by the finger-nail, leaving a number of bleeding points upon the surface of the denuded corium. The patient was in good physical condition, and complained of nothing save the eruption.

In this respect he was like the majority of psoriatic patients, since the disease seems to manifest a predilection for robust and well-nourished subjects.

It will be noted that the eruption is symmetrical, as is usual in psoriasis, but the guttate lesions are not as rounded as they often appear in this disease, and consequently bear a resemblance to pityriasis maculata. Indeed, it is difficult in some cases of mild psoriasis to distinguish the eruption at first glance from pityriasis (seborrhœic eczema), but the characteristic tendency of the psoriatic eruption to recur at certain seasons, year after year, will usually settle the question of diagnosis. It will be further noted that in this case there are no erythematous spots. While congestion exists beneath the patches of thickened epidermis, all that can be seen of the eruption are white silvery scales with a line of redness at the border.

Under a restricted diet and an alkaline diuretic taken before meals, with cold baths and the inunction of salicylated vaseline, the eruption speedily disappeared.



PSORIASIS GUTTATA.

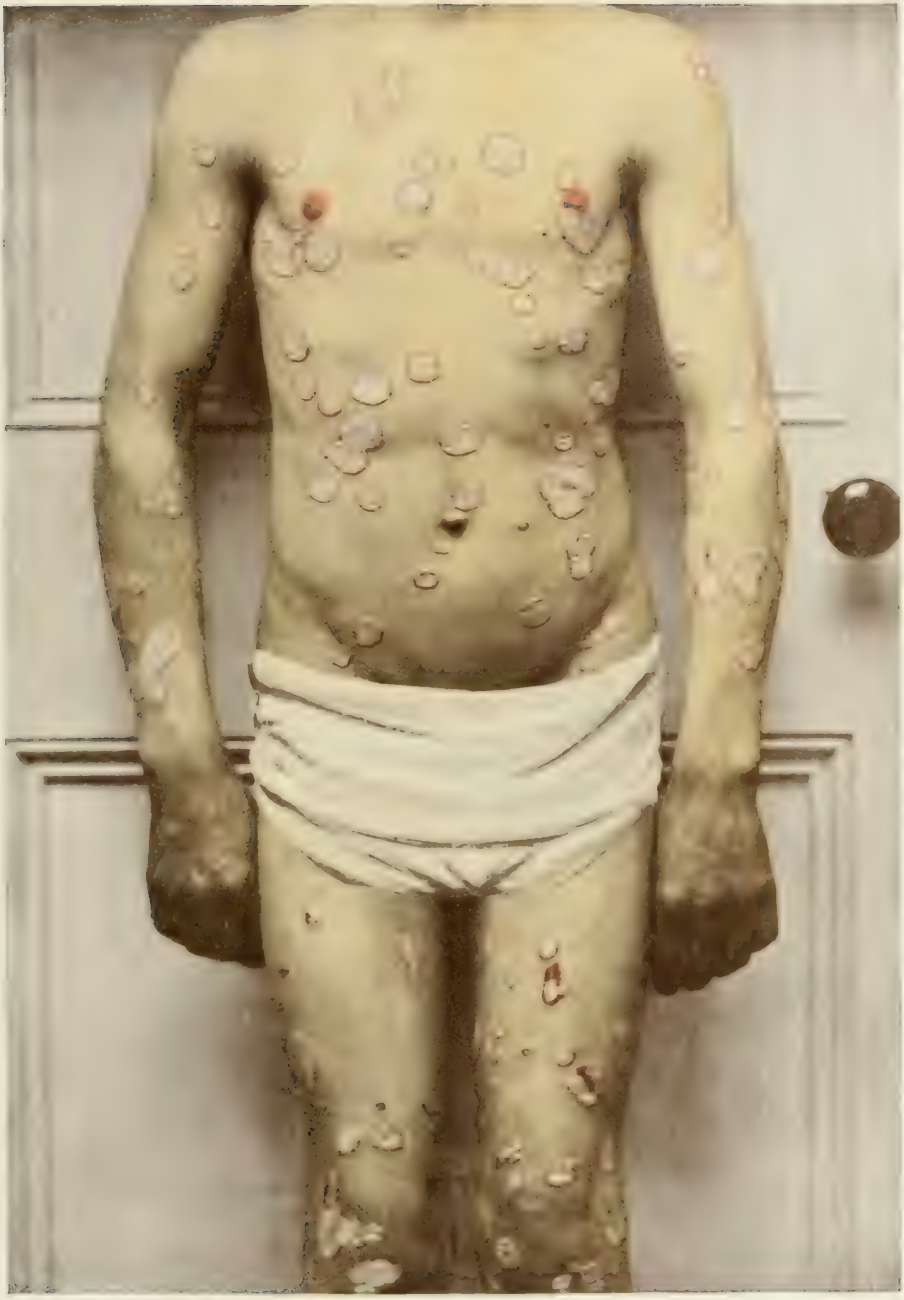
# PLATE LXIII.

PSORIASIS NUMMULATA

## PSORIASIS NUMMULATA

The psoriatic eruption presents a great diversity of appearance in different patients, although rounded and circumscribed patches covered with silvery or yellowish white scales are characteristic of all cases. The eruption is nearly always symmetrical, whether the scaly lesions be punctate, guttate or nummular in size or occur in large diffused patches. Although the extensor surface of the extremities, and particularly the region of the elbows and knees, is most frequently affected, the trunk in some cases may be the principal seat of the disease.

The boy who was the subject of the illustration presented an eruption of the nummular or coin-like form. Both trunk and extremities were the seat of numerous rounded and scaly patches, varying somewhat in size, but bearing a sufficiently strong resemblance to silver coins stuck upon the skin to warrant the use of the descriptive adjective. All of the larger lesions show an elevation of the border and a corresponding depression of the central portion of the patch. Upon the thigh a portion of the thick whitish scale has evidently been scratched off from some of the patches, leaving exposed a red and slightly elevated surface. The boy was admitted as a patient at the Skin and Cancer Hospital, and in a few weeks was quite free from the eruption—the regularity of sleep, diet, etc., doing as much for him perhaps as the special treatment employed.





PSORIASIS NUMMULATA.

PLATE LXIV.

PSORIASIS CIRCINATA

## PSORIASIS CIRCINATA

The circinate form of psoriasis results from a tendency of the rounded, marginate patches to heal in the centre while the border remains thickened and scaly. This is noted in certain cases particularly of the nummular or diffused type. The small lesions do not develop in a circle and enclose a healthy area, as sometimes happens in the tubercular syphilide, but as the patch enlarges in a serpiginous manner the raised scaly border often breaks into small guttate segments.

The accompanying plate shows a case of psoriasis which had lasted for many years, increasing in extent at times and then almost disappearing. This increase and decrease of the eruption, which is a characteristic feature of psoriasis, is due partly to the change of seasons and partly to the change of food which this involves. It also depends upon accidental conditions which exert an influence upon the health and vigor of the patient. The eruption is commonly worse in winter than in summer, and many patients note a marked tendency to an exacerbation in either the spring or autumn months. While it is true that the victims of psoriasis are, as a rule, robust and well nourished individuals, it is also to be noted that in a given case the tendency to the outbreak of new lesions depends largely upon conditions which tend to impair the health or to produce mental or physical exhaustion.



PSORIASIS CIRCINATA.

PLATE LXV.

PSORIASIS GYRATA

# PSORIASIS GYRATA

The pioneers in dermatology were accurate observers and carefully noted the variations in clinical form which the common skin diseases are liable to present. While they may have laid undue stress upon certain peculiarities of configuration, we are certainly indebted to them for many descriptive adjectives which are still in use and which convey to the mind a clear impression of the most striking clinical features of an eruption. Psoriasis is always of the same nature whatever form the eruption may assume, but for descriptive purposes, terms like punctata, guttata, nummulata, circinata, gyrata, and diffusa are of great convenience.

While in many cases of psoriasis the lesions may retain a punctate or guttate form, there is usually a tendency of the scaly discs to enlarge peripherally. In this manner are produced the nummular or coin-like and the large rounded diffused patches. When small rounded patches coalesce an irregular patch with a scalloped border is formed. Frequently the psoriatic disc manifests a notable tendency to heal in the centre, like ringworm and syphilitic lesions. In this manner is produced the circinate form of psoriasis, and when the ring develops in a serpiginous or creeping manner, part of the circle is apt to disappear, leaving a gyra or curved line of silvery scales.

In the illustration may be noted guttate, diffused, circinate and gyrate lesions, and also the pigmentation of the skin which is frequently left after the disappearance of a psoriatic patch.



PSORIASIS GYRATA.

# PLATE LXVI.

PSORIASIS DIFFUSA

## PSORIASIS DIFFUSA.

Psoriasis of long standing usually assumes the diffused form. In rare cases the first attack may affect a large portion of the skin, and not infrequently the disease may retain the guttate or nummular form for many years either continuously or in recurring attacks. Still it may be regarded as a rule that the more chronic cases are the ones which present large rounded or irregular patches of diseased skin. These are formed by the gradual confluence of smaller lesions and are generally characterized by an excessive accumulation of epidermic scales. Such patches are not only intensely pruritic but often extremely painful, owing to the fissures produced by motion of the body. Sometimes large masses of dried scales become loosened and are finally torn or rubbed off, leaving a dull red and tender skin exposed to view.

The accompanying illustration shows many guttate spots upon the trunk and region of the elbows as well as diffused patches upon the back. The patient had suffered from the disease for many years and the localization of the eruption around the waist was doubtless the result of his wearing a tight belt, since it is frequently noted that pressure or local irritation of any kind is apt to determine the site of psoriatic patches. The eruption is quite typical over the sacral region, which is a favorite site of the disease, but the unsymmetrical appearance presented by the scapular regions is somewhat unusual.

PSORIASIS DIFFUSA.

# PLATE LXVII.

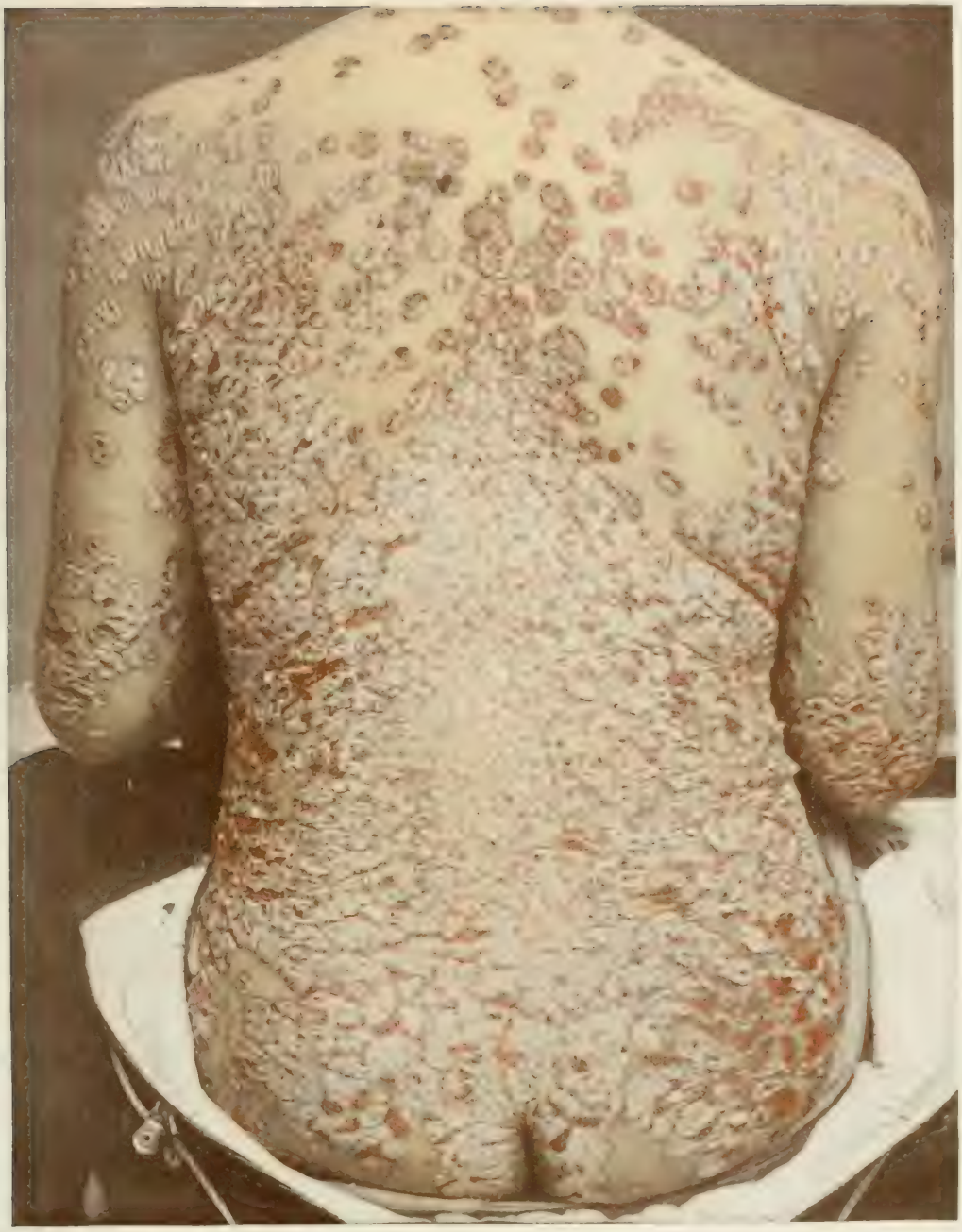
PSORIASIS EXFOLIATIVA

## PSORIASIS EXFOLIATIVA

The scales of psoriasis are usually adherent except in cases where, from the severity of the disease or from lack of daily ablution, they have become unusually thickened. Under such circumstances the scales tend to disintegrate and fall to such an extent that when the patient removes his clothing a considerable quantity can be gathered from the floor.

An extensive psoriatic eruption occasionally becomes the seat of an acute inflammatory process. The scales then form rapidly and tend to become less adherent. To this condition the term psoriasis exfoliativa may be properly applied. The acute inflammation often involves the whole body, the imbricated and adherent scales give place to large flakes of peeling epidermis, and the psoriatic eruption gradually loses its distinctive character and finally merges into an affection of the skin known as dermatitis exfoliativa, and which is illustrated in the following plate.

The accompanying plate portrays a confluent nummular eruption which covers the greater portion of the back. The patient was of intemperate habits and an extensive eruption was certain to follow every prolonged debauch.





PSORIASIS EXFOLIATIVA.

## PLATE LXVIII.

PSORIASIS ECZEMA

SYPHILODERMA SARCOMA

PSORIASIS ECZEMA
SYPHILODERMA SARCOMA

This plate shows four distinct diseases affecting the leg, although in no case is this locality the exclusive or even the favorite site of the eruption. Either disease may involve almost any part of the body.

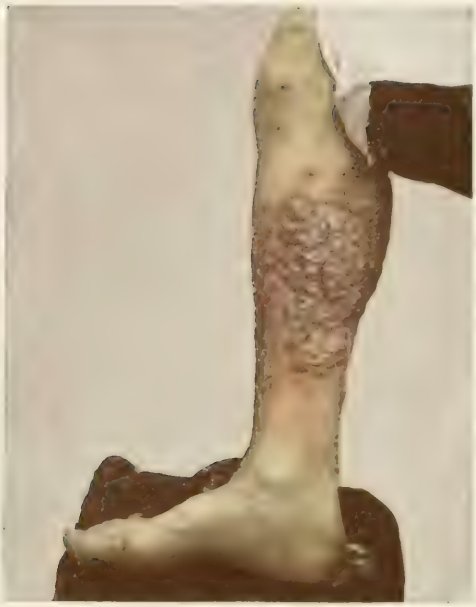
Psoriasis is characterized by the sharply circumscribed borders of the patches, whether these be large or small. It is apparent that in this case a number of guttate or nummular lesions have coalesced, forming irregular patches, with a well-defined and scalloped border. Under ordinary circumstances they would be covered with silvery scales, but treatment had removed these before the case was photographed, and only the reddened and slightly infiltrated skin is seen.

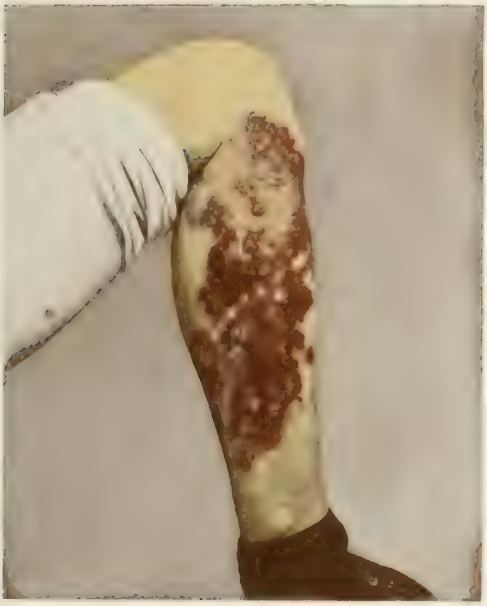
Eczema, on the other hand, is characterized by a lack of any defined margin. The eruption almost invariably shades off gradually into the surrounding healthy skin.

In the illustration is seen the impetiginous or crusted form of eczema. Had these crusts been removed by scrubbing, as were the scales in the case of psoriasis, a bright red exuding surface would have been exposed (*E. rubrum*).

The scaling tubercular syphilide may sometimes resemble psoriasis, but it is more nodular and far less scaly. It often presents an ulcerated or cicatrized surface, never seen in the latter eruption. It is formed by the coalescence of nodules instead of scaly discs, and therefore presents a more uneven surface.

Sarcoma may usually be distinguished from syphilis, by the absence of any tendency to the grouping of lesions in a circular form, and by the dusky or bluish pigmentation of the skin in place of the dull reddish-brown hue of the syphilide.







PSORIASIS.
SYPHILODERMA.

ECZEMA.
SARCOMA.

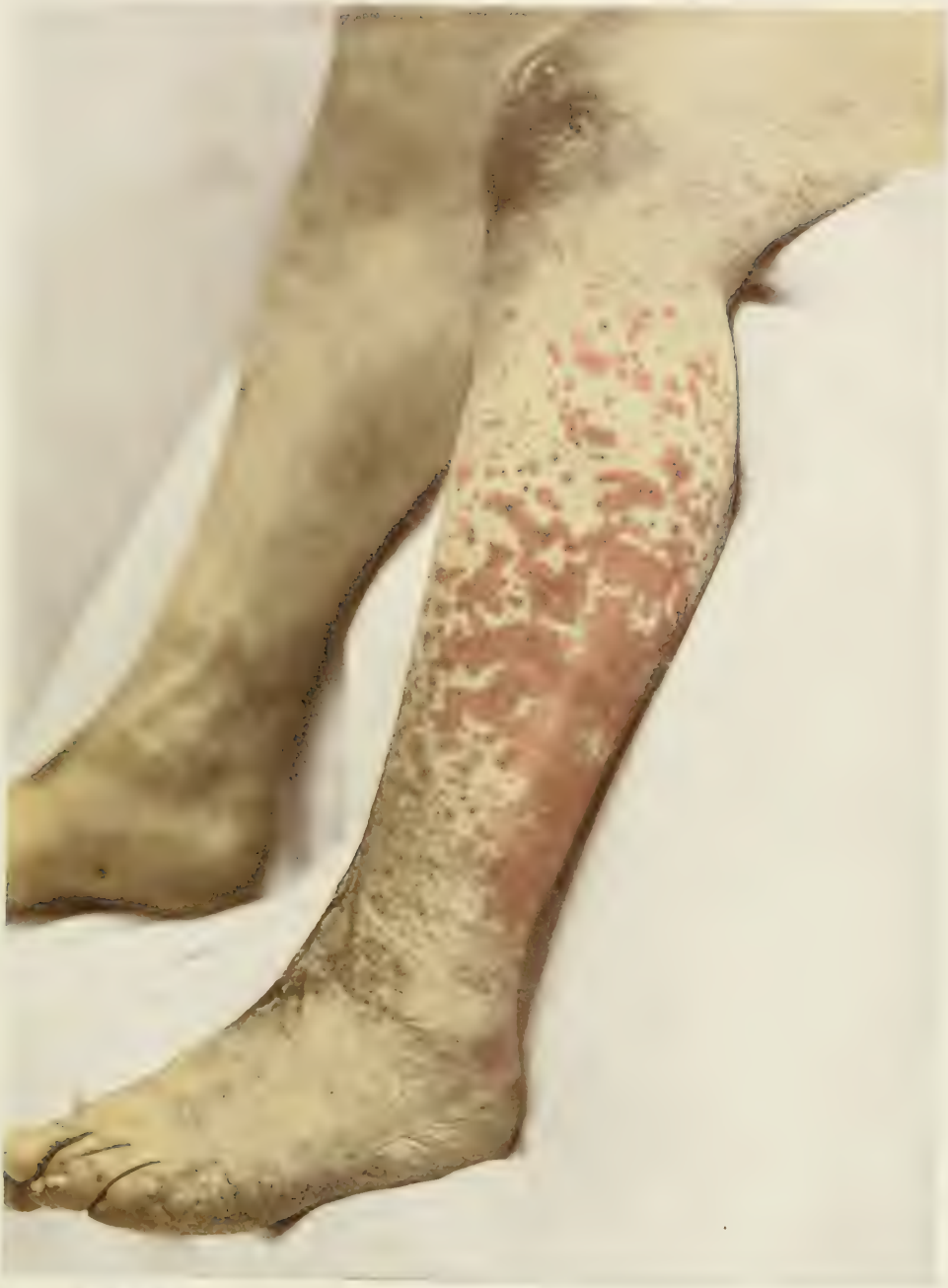
# PLATE LXIX.

PURPURA

# PURPURA

Hemorrhage into the cutaneous tissues, when spontaneous and superficial, gives rise to an eruption of smooth lesions of varying size known as purpura simplex. These are bright blood-red spots at the outset, becoming dull or purplish after a few days. In some cases they do not increase in size, but usually they enlarge and often coalesce into patches. When the hemorrhage occurs in the follicles the lesions may be elevated (purpura papulosa). In severe cases there is usually more or less bleeding from some of the mucous membranes (purpura hemorrhagica). When this hemorrhagic purpura is the result of a prolonged abstinence from vegetable food, the disease is commonly known as scurvy (purpura scorbutica).

The accompanying plate shows a well-marked case of purpura in its most common form. The man was a patient in my service at the Skin and Cancer Hospital and had suffered from recurring attacks of purpura of the lower extremities. The present eruption began with numerous small bright-red spots, such as are seen around the popliteal space and above the ankle. Upon the middle portion of the legs they rapidly increased in size, coalesced into irregular patches, and assumed a dull purplish hue. With rest in bed and the administration of the tincture of the chloride of iron in full doses the eruption faded away in about two weeks' time, the patches passing through those gradations of color which are characteristic of a disappearing bruise.





PURPURA.

PLATE LXX.

ROSACEA ERYTHEMATOSA

## ROSACEA ERYTHEMATOSA

The three forms in which rosacea may appear are commonly described as the erythematous, the pustular, and the hypertrophic. The accompanying portrait represents a combination of the first two types, although the erythematous element is the most marked. The nose and malar regions are the favorite seat of the affection, but in this case, one of long standing, the whole lower portion of the face is involved. The cheeks and chin present numerous indolent nodules some of which show a tendency to suppuration. Between and over these a persistent passive congestion gives to the skin its characteristic rubicund color.

This affection is frequently described as a form of acne (acne rosacea), but it differs in several essential respects. It is not primarily of follicular origin. There are never any comedos or other evidence of follicular disturbance such as is invariably present in cases of acne, and the disease is usually noted at a more advanced age. Indeed, it commonly begins at about the age when the ordinary acne of youth begins to disappear spontaneously, and most patients over thirty who suffer from rosacea will be found to have shown little or no disposition to acne during their teens.

ROSACEA ERYTHEMATOSA.

# PLATE LXXI.

ROSACEA PUSTULOSA

# ROSACEA PUSTULOSA

The patient represented in the accompanying plate had suffered from rosacea for many years. This may be readily judged by the pitted condition of the malar region which had evidently been the seat of many suppurating nodules. The forehead was dotted with numerous large indolent pustules in various stages of development. The nose had gradually assumed a purplish tinge and at times was slightly increased in size.

The cause of rosacea varies in different cases, but a chronic indigestion is usually present and is often associated with a feeble circulation. These conditions predispose to a frequent flushing of the face and a stagnation of blood in and about the nose. Though the lesions in this affection, especially in the pustular form, are sometimes justly spoken of as "rum blossoms," it must be remembered that the bright redness of the nose or the dull red nodules in its vicinity, or even a considerable hypertrophy of the organ, may sometimes occur in patients who have never been addicted to the use of alcoholic beverages.

The most successful plan of treatment consists in a combination of local and constitutional measures. While a radical change of habits and general treatment of the patient is usually necessary in striking at the root of the disease, a marked improvement can often be effected by vigorous curetting, soap frictions, and the application of the most stimulating ointments and lotions.

ROSACEA PUSTULOSA.

PLATE LXXII.

ROSACEA HYPERTROPHICA

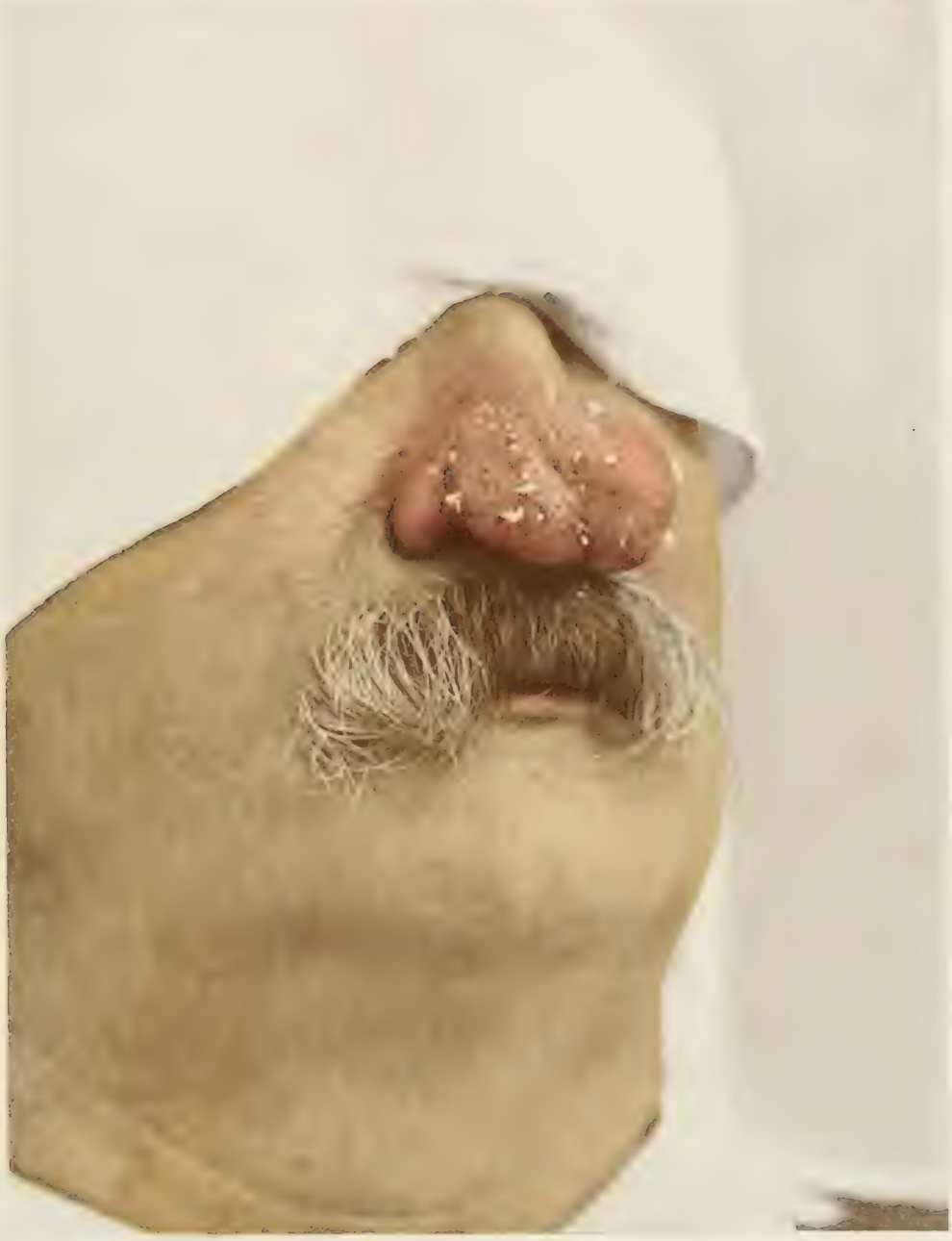
## ROSACEA HYPERTROPHICA

The hypertrophic form of rosacea is not frequently met with, but when it does occur it usually presents a peculiarly striking appearance. In most cases the increase of growth is limited to the tip and wings of the nose. Though red and swollen in appearance the nose feels cold and flabby to the touch. The mouths of the sebaceous follicles are abnormally patulous and dilated blood vessels often appear upon the surface. In time the increase of growth produces large lobular masses and the red color of the nose changes gradually to a dull purplish or livid hue. In rare instances the enlarged nose becomes pendulous, resting upon the upper lip and presenting a marked deformity (rhinophyma).

When the whole nose is enlarged without the formation of soft lobular masses the surface presents a smooth red appearance, or is of a venous tint and often dotted with numerous follicular pits, which give the organ a worm-eaten appearance.

The accompanying plate illustrates a case of moderate degree in which redness, swelling and incipient lobulation were the chief features. The sebaceous glands of the tip and wings of the nose were greatly distended by their contents. Just before the photograph was taken the nose was vigorously pinched and numerous masses of white, cheesy sebum forced out of the follicular openings.

The patient was a gentleman in good general health who had never indulged in alcoholic beverages to an unusual extent.



ROSACEA HYPERTROPHICA.